PROPOSALS TO EXTEND MEDICARE COVERAGE TO THE NEAR-ELDERLY

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

MARCH 19, 1991

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PROPOSALS TO EXTEND MEDICARE COVERAGE TO THE NEAR-ELDERLY

TUESDAY, MARCH 19, 1991

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The committee met, pursuant to notice, at 10:12 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
TUESDAY, MARCH 12, 1991

PRESS RELEASE #4
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
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THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING ON
PROPOSALS TO EXTEND MEDICARE COVERAGE TO THE NEAR-ELDERLY

The Honorable Fortney Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on proposals to extend Medicare coverage to the near-elderly. The hearing will be held on Tuesday, March 19, 1991, beginning at 10:00 a.m. in room 1100 Longworth House Office Building.

In announcing the hearing, Chairman Stark said, "The absence of universal health insurance is a national disgrace. While the Subcommittee continues its consideration of comprehensive solutions, we must work simultaneously to fill gaps and expand coverage where and whenever possible."

Oral testimony will be heard from **invited witnesses only**. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

This will be the second hearing of this Congress in the Subcommittee's ongoing consideration of incremental improvements in coverage under the Medicare program. The Subcommittee will consider options to expand the Medicare program to groups other than the aged, disabled and end stage renal disease populations.

The hearing will focus on proposals to expand Medicare coverage to three groups of near-elderly persons, ages 62 through 64, who are without health insurance: (1) early retirees receiving Social Security benefits; (2) spouses and dependents of Medicare beneficiaries; and (3) individuals entitled to Social Security Disability Insurance (SSDI) benefits who are not yet covered by the Medicare program.

According to recent studies, 11.5 percent of persons ages 62 through 64 are without health insurance. Approximately 400,000 early retirees who receive Social Security benefits are uninsured. An estimated 600,000 spouses of Medicare beneficiaries and 300,000 dependents are uninsured. Another 75,000 Social Security disability beneficiaries are uninsured, but have not met the two-year waiting period requirement to become eligible for Medicare benefits.

Among the near-elderly, lack of health insurance can be a particularly serious concern for a number of reasons. First, uninsured persons ages 62 through 64 tend to be in fair or poor health and at risk for substantial medical expenses. Second, they are more likely to have low incomes making it more difficult to obtain health insurance on their own.

(MORE)

Finally, unlike younger cohorts of uninsured persons, the near-elderly are more likely to be detached from the labor market, and, therefore, least likely to benefit from options that link the expansion of health insurance to employment.

Among other proposals, consideration will be given to legislation to be introduced by Chairman Stark and Mr. Coyne (D., Pa.) prior to the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Tuesday, April 9, 1991, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

Chairman STARK. The Subcommittee on Health of the Ways and Means Committee will begin this morning to consider further incremental improvements in the Medicare program. We will focus on proposals to expand Medicare to cover near-elderly persons without health insurance.

We'll examine proposals for older adults who the system doesn't catch in the safety net, those who reach their early sixties and find themselves in poor health, with modest or no income, but not old enough for Medicare, and unable to obtain health insurance, who find themselves in a position where celibacy and not having a divorce, as Dr. Sullivan suggests, doesn't do much for them.

While many members of this subcommittee share my interest in seeking a comprehensive solution to the problems of the uninsured, we're also committed to making improvements in the coverage wherever and whenever we can.

About 11½ percent of the individuals between the ages of 62 and 64 are without health insurance. The absence of health coverage for people in their early sixties can be particularly serious for a number of reasons.

First, between the ages of 62 and 64, uninsured persons tend to be in fair to poor health and higher at risk for substantial medical expenses.

Second, they are more likely to have low incomes. According to a survey conducted by Louis Harris, half of the low-income older adults are uninsured, making it more difficult to obtain health insurance on their own.

Finally, the near-elderly are less likely than younger people to have ties to the labor market. Consequently, they are least likely to obtain employment based health insurance.

It should be emphasized that the majority of nonworking older Americans do not receive health insurance coverage from a former employer. Retiree health benefits are limited and affect primarily higher income individuals.

Among other proposals, today's hearing will consider H.R. 1444, a bill introduced by the chair, Mr. Coyne and Mr. Moody. This bill would expand Medicare eligibility criteria to cover three groups of near-elderly persons.

First, the 24-month Medicare waiting period would be waived for individuals entitled to Social Security disability beneficiaries, beginning at age 62. That would cover some 75,000 individuals who fall into that category.

A second group assisted by this proposal includes early retirees who receive monthly Social Security benefits. They would be given an opportunity to purchase Medicare part A and part B.

Third, the spouses of Medicare beneficiaries, age 62 and older, and child dependents would also be given an opportunity, again, and I emphasize, to purchase Medicare.

To enter the sixth decade of life without health insurance poses enormous problems. Uninsured people in their early sixties are likely to find individually sold policies unaffordable if they can find them at all. Where they exist, a few are priced as low as $3,000 to $4,000 a year, $250 to $350 a month, which practically excludes most people in this age group. What's worse, those with preexisting medical conditions may not be able to find any insurance company

that will sell them a policy to cover their medical conditions regardless of price.

As a final point, let me note that H.R. 1444 has been drafted without necessary revenues to cover the costs. I fully anticipate that these benefits, if adopted, will be financed in the usual pay-as-you-go basis.

I look forward to the testimony of our witnesses this morning. The first of which is our old friend, Dr. Gail Wilensky, who is the Administrator of the Health Care Financing Administration. We're pleased to welcome you back, Gail. Would you like to proceed with your testimony in any manner you're comfortable?

If you will suspend for a moment, did any of the other members of the panel have a statement?

Mr. MOODY. Mr. Chairman.

Chairman STARK. Mr. Moody.

Mr. MOODY. First of all, I don't think our witness looks that old.

Ms. WILENSKY. Thank you.

Mr. MOODY. Mr. Chairman, I salute you for having these hearings. I think they are extremely timely. In my part of Wisconsin, there is no issue which is pressing in on family budgets more than health care, the rising bill for health care, and the fear of the rising bill for people as they look out towards the future.

I recognize that we have a health care system for the over 65, but for those under 65, it's still a very dangerous world financially as they look to the future of recognizing that more and more new jobs created in Wisconsin do not have health care associated with them.

Just a quick statistic, in 1982, in the depths of the recession, Wisconsin had about 250,000 people uninsured with 11 percent unemployment. Today, with 5 percent unemployment, much lower than the Nation's average, we have over 500,000 uninsured. Double the number of uninsured people in my State, many of them would be potentially eligible for something like this.

Even though we have cut the unemployment role substantially, to a very healthy level in terms of unemployment, we're at a rapidly escalating level in terms of people who are not covered with any health insurance whatsoever. Those are startling statistics for anyone who follows these matters. I think the chairman is to be saluted for his scheduling this hearing.

Thank you.

Chairman STARK. Gail.

STATEMENT OF GAIL R. WILENSKY, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. WILENSKY. Thank you. Mr. Chairman and members of the subcommittee, thank you for the opportunity to discuss proposed expansions of Medicare coverage to include near-elderly individuals.

We are well aware of the difficulty many Americans face in finding ways to finance their health care. The question that faces us, as a society, is how to apportion responsibility for paying for health

care coverage among individuals, the public sector, and private financing arrangements.

We have several major concerns with H.R. 1444. First, expanding eligibility for Medicare without ensuring adequate funding jeopardizes the entire program. A very preliminary cost estimate, and I need to emphasize that it is very preliminary, indicates that the bill would increase Medicare spending by at least $5.1 billion in 1992 and over $24 billion in a 4-year period.

Cost is an important consideration given the financial pressures on the existing program. In fiscal year 1992, without any legislative changes, Medicare program expenditures are expected to increase by about 13 percent. The trust fund is already insufficiently financed and will be depleted shortly after the turn of the century. We need to take action to avoid this impending crisis. H.R. 1444 would do exactly the opposite and threaten us with the crisis sooner.

We are also concerned that expanding eligibility for Medicare would increase incentives for early retirement. More than a decade of research on retirement indicates that the age when retirement related benefits are available affects decisions about when to retire. Early retirement would decrease the size of the active work force, further damaging our lagging productivity and impairing our competitive position internationally. Benefits available to early retirees would increase. However, those remaining in the work force would need to be taxed more heavily to pay for the increased benefits and this is of concern to all of us.

The Medicare program has traditionally been tied to Social Security. At a time when the normal retirement age for Social Security is being increased, H.R. 1444 would do the reverse for Medicare. The normal retirement age for Social Security will begin to rise to 67 in the year 2000.

In 1983, the Advisory Council on Social Security specifically reviewed age as a Medicare eligibility factor. The Council recommended that the age of eligibility for Medicare benefits be raised to 67. This recommendation would prolong the financial solvency of the Medicare program and ensure Medicare protection to the elderly most in need of services.

Social Security has a built in mechanism to restrain program expenditures when individuals choose to retire before the age of 65. The benefits of early retirees are reduced, making the retirement decision budget neutral over the longrun. Medicare does not lend itself to this kind of a reduction. One either has Medicare protection or one does not.

Changes in the age of eligibility are appropriate. The number of years a retiree can expect to be covered by Medicare has increased dramatically. Life expectancy has increased as much as 5 years since 1965. The burden on workers supporting the retired population has increased markedly. Currently, there are approximately four workers paying into the Medicare Hospital Insurance Trust Fund for each beneficiary. This ratio declines to three workers by 2010 when the baby boomers begin to retire. By 2040, there will be only two workers per beneficiary.

This declining ratio is a critical reason to carefully consider any Medicare eligibility expansions that would increase the financial

pressure on the trust fund. H.R. 1444 takes an incremental approach to expanding access to care without a clear vision of an ultimate goal. I am not against incrementalism, but I believe that we have to explore the broader issues of cost, equity and access to health care and be careful that piecemeal changes to fill coverage gaps lead us in the direction that we want to go and not in another direction.

It is unclear why we should target the near-elderly. Compared to other age groups, the near-elderly are more likely to have health insurance, and individuals between 60 and 64 appear to be better off with incomes above the national average.

By far, the largest impact of H.R. 1444 would be made by covering early retirees. We estimate that this would result in an additional $3.2 billion in Medicare spending in 1992. Expanding coverage to spouses and dependents of Medicare beneficiaries would diverge from the premise of current eligibility. Spouses of Medicare beneficiaries must wait until age 65 to become eligible. Dependents, generally, cannot become eligible for Medicare through their parents. Expanding coverage to near elderly spouses would cost Medicare $650 million in 1992. Covering near-elderly widows and widowers would cost about $590 million.

H.R. 1444 would also eliminate the 24-month wait before near-elderly disabled individuals become eligible for Medicare. Congress mandated this waiting period for several reasons. The waiting period avoids overlap with private health insurance protection. This restrains spending without impairing access to health care. Individuals with severe and long lasting disabilities will continue to be protected. We estimate that the newly disabled would increase Medicare spending by about $650 million in 1992.

Before we act on eligibility expansions, it is important to understand fully their cost implications. We have found that over the years, the solvency of the trust fund is sensitive to changes in coverage and eligibility and needs to be dealt with responsibly and prudently. Expanding Medicare eligibility, as proposed by H.R. 1444, does little to address the larger issues of access to care.

The importance of this issue is evidenced by the large number of groups established to address this problem and to recommend solutions. I know you are very well aware of the many groups who are looking at this issue.

In summary, we believe the expansions to Medicare eligibility proposed by H.R. 1444 are premature and not advisable. The viability of a proposal to improve access to health care depends on the extent to which it falls within the realm of our comprehensive efforts. It would be unwise to promote a fragmented approach, especially one that is not financially sustainable until we have decided the direction that we wish to go as a Nation.

We are eager to work with you as you develop and as we develop a more thorough strategy to ensure that Americans have access to the health care they need. I'd be pleased to answer any questions that you may have.

[The prepared statement follows:]

STATEMENT OF GAIL R. WILENSKY, PH.D., ADMINISTRATOR,
HEALTH CARE FINANCING ADMINISTRATION,
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to discuss proposed expansions of Medicare coverage to include near-elderly individuals.

We are well aware of the difficulty many Americans face in finding ways to finance their health care, and we share your concern for improving access to care. The question, however, that faces us as a society is how to apportion responsibility for providing and paying for health care coverage among individuals, the public sector, and private financing arrangements.

Concerns with H.R. 1444

H.R. 1444 would expand Medicare eligibility to three groups of persons: early retirees receiving Social Security benefits; near-elderly spouses and some dependents of Medicare beneficiaries; and disabled individuals. Early retirees, spouses, and dependents would pay only about a third of the premium that other ineligibles must pay for part A of Medicare. Near-elderly disabled individuals would be entitled to Medicare without paying an additional part A premium.

We have several major concerns regarding this proposal. First, expanding eligibility for Medicare without ensuring adequate funding jeopardizes the entire program. A very preliminary cost estimate of H.R. 1444 indicates net increased expenditures of at least $5.1 billion in 1992. Cost is an important consideration given the financial pressures on the existing program. In fiscal year 1992, without any legislative changes, Medicare program expenditures are expected to increase more than 13 percent.

The trust fund is already insufficiently financed and, under current law, will be depleted shortly after the turn of the century. We need to take action to avoid this impending crisis. H.R. 1444 would do exactly the opposite, and threaten us with the crisis sooner.

We also need to assess the impact on the federal budget deficit of requiring additional spending from general revenues to support payment for part B services to newly eligible beneficiaries.

Expanding eligibility for Medicare would increase incentives for early retirement. More than a decade of research on retirement indicates that the age when retirement-related benefits are available does affect workers' decisions about when to retire. Making Medicare benefits available to early retirees and to near-elderly spouses of Medicare beneficiaries will cause more workers to retire earlier. Benefits available to retiring workers would increase, while those who remain in the work force would need to be taxed more heavily to pay for these increased benefits. This is a bad deal for the worker.

From its inception in 1965, the Medicare program has been closely tied to Social Security -- the Old Age, Survivors, and Disability Insurance programs. At a time when the normal retirement age for Social Security is being increased, H.R. 1444 would do the reverse for Medicare. The normal retirement age was set at 65 in 1935, but will rise to 67 beginning in the year 2000 as a result of the Social Security Amendments of 1983.

In 1983, the Advisory Council on Social Security specifically reviewed age as a Medicare eligibility factor. The Council recommended that the age of eligibility for Medicare benefits be raised to 67. This recommendation would prolong the financial solvency of the Medicare program and ensure Medicare protections to the elderly most in need of services.

Social Security has a built-in mechanism to restrain program expenditures when individuals choose to retire before the normal retirement age. The benefits of those who retire early are reduced for each month they retire before age 65, thus making the retirement decision budget neutral over the long run. Medicare

does not lend itself to this kind of reduction -- one either has Medicare protection or one does not.

Changes in the age of eligibility are appropriate considering the increase in life expectancy and decrease in the ratio of workers paying taxes to retirees receiving retirement benefits. The number of years a retiree can expect to be covered by Medicare has increased dramatically since the program began. Life expectancy was estimated at 67 years for males and 74 years for females in 1965. In 1990, male and female life expectancy had grown to 72 and 79, respectively.

The burden on active workers supporting the retired population has increased markedly, and is expected to rise further after the turn of the century when the "baby boom" generation retires. Currently, there are approximately four workers paying into the Medicare Hospital Insurance Trust Fund for each beneficiary. This ratio declines to 3.5 workers for every beneficiary by 2010 and to two workers per beneficiary by 2040. This declining ratio is a critical reason to carefully consider any Medicare eligibility expansions that would increase the financial pressure on the trust fund.

H.R. 1444 takes an incremental approach to expanding access to care without any clear vision of an ultimate goal. Until we have explored the broader issues of cost, equity and access in our health care system, piecemeal changes to fill coverage gaps may be costly, misleading, and ultimately counter productive.

For example, it is unclear why we should target the near elderly. Compared to other groups, the near elderly do not exhibit a striking or obvious need. In fact, compared to all other age groups, the near elderly are more likely to have health insurance. Financially, individuals between 60 and 64 have considerably more income than young adults.

Impact of New Eligibility Groups

By far, the largest impact of H.R. 1444 would come from covering early retirees. We estimate this would result in an additional $3.2 billion in Medicare spending in 1992.

H.R. 1444's expansion of coverage to spouses and dependents of Medicare beneficiaries would diverge from the premise for current eligibility. Individuals now become eligible for Medicare when they reach normal retirement age or become disabled. Spouses of Medicare beneficiaries must wait until age 65 to become eligible. Dependents generally cannot become eligible for Medicare through their parents. Expanding coverage to near-elderly spouses would have a net cost of $650 million in 1992. Expanding cover to near-elderly widows and widowers would cost the Medicare program $590 million.

H.R. 1444 would also eliminate the current 24-month wait before near-elderly disabled individuals become eligible for Medicare. Congress mandated this waiting period for several reasons. The waiting period avoids overlap with private health insurance protection, and thereby restrains spending without impairing access to care. Individuals with severe and long-lasting disabilities will be protected.

We estimate the number of newly disabled between the age of 62 and 65 would be 50,000. These new beneficiaries would increase Medicare spending by $650 million in 1992.

Before we act on eligibility expansions, it is important to understand fully the cost implications. We have found over the years that the solvency of the trust fund is sensitive to changes in coverage and eligibility and needs to be dealt with responsibly and prudently.

Understanding the Uninsured Problem

Expanding Medicare eligibility, as proposed by H.R. 1444, does little to address the larger issue of access to care. The importance of this issue is evidenced by the number of groups established to address these problems and recommend solutions.

The U.S. Bipartisan Commission on Comprehensive Health Care -- the Pepper Commission -- has already issued its report of findings, and the Social Security Advisory Council is also expected to come forth with its recommendations. The National Governors Association has designated health care reform as its number one priority for this year and is conducting a study that is expected to be complete by August 1991.

A special Departmental Task Force is also charged with exploring solutions to problems of health care access, equity, and cost. I serve as Vice-Chair of the Task Force. We also want to study carefully results of the other major groups. The benefits that H.R. 1444 would provide may not coincide with their findings.

Conclusion

In summary, the expansions to Medicare eligibility proposed by H.R. 1444 are premature and inadvisable. The viability of any proposal to improve access to health care services will depend on the extent to which it falls within the realm of our comprehensive efforts. It would be unwise to promote a fragmented approach, especially one which is not financially sustainable.

We are eager to work with you as we develop a more thorough strategy to ensure that Americans have access to the health care they need.

I would be pleased to answer any questions you may have.

Chairman STARK. Mr. Coyne.

Mr. COYNE. Thank you, Mr. Chairman. It is pretty clear that you oppose H.R. 1444. It is also very clear that you recognize that there is a problem that has to be addressed. What is your recommendation for addressing the problem?

Ms. WILENSKY. I think you know as a result both of the statements that I have made here and the statements that members of HCFA have made when I have not been here, that the administration at the present time has not taken a position with regard to expanding access. We have, as you are well aware, activities in the Department that are ongoing under the leadership of Connie Horner, our Deputy Secretary.

It is our expectation that we will be making recommendations to the White House later in 1991. As I have indicated, I am not at all against incrementalism. In fact, I fully believe that we will ultimately do something in an incremental way. This bill takes a position that it will be by expanding Medicare. Until there is some agreement in this country as to how we wish to address the problem of those without health insurance, I do not think incremental expansions that may go in a different direction from the way we ultimately want to go are advisable.

So the answer is we are not prepared to make recommendations for expansions, particularly ones that cost the enormous amount of money that our actuaries told us this one would cost.

Mr. COYNE. From your statement, are we to assume that you are not going to act until there is total unanimity in the country on a program?

Ms. WILENSKY. No, I do not know that we will take the position that we are not going to act until there is total unanimity. I think on the issue that you are raising—are we ready to act now; do we believe that there is agreement in terms of the direction we want to take—the answer is no. And I believe the answer is no for at least a couple of reasons.

One, the issue of how we are going to address cost containment and bring the costs in the health care system within reasonable range has not been agreed upon. And I do not personally believe and I believe it is the position of the administration, that there will not be any significant moves to expand access unless we have some credible ways to show that we know how to restrain health care expenditures. Thus far we have not been able to do so.

And second, the issues that fundamentally need to be addressed, which is whether or not we are going to consider major additions to spending on health care or whether we are going to attempt to redirect the very large amounts of spending already going on in our health care system, have also not been agreed upon.

Mr. COYNE. Is it reasonable to expect that maybe towards the end of the year we will have a recommendation on correcting the problem from HCFA?

Ms. WILENSKY. I think that by the end of the year there will be some options and recommendations that will go to the White House. I am not in any position to say whether or not the administration will come out with either a general or a specific program at that point. But I think that there will be results from the work that the Department has been doing as well as the other studies

that the Department has either expressed interest in or commissioned, such as the Advisory Council on Social Security. That is due to be finished in the next couple of months.

I know there has been interest expressed also in the work that that National Governors' Association is undertaking.

Mr. COYNE. Thank you.

Chairman STARK. I guess we have a question here of which highly placed, patriotic, concerned public official do you believe. Now I want to try to have a little test this morning. I have two quotes talking about problems of arguably low income folks.

One famous American would say that low income and medically uninsurable should be subsidized by the State or Federal Government on the grounds that these individuals unlike the vast majority of nonaged individuals who have employment related health insurance are not receiving any subsidy from the tax exclusion accorded to employment related health insurance and additionally unless limited subsidization is provided it is likely that such insurance would be prohibitively expensive.

Another highly placed member of the administration says that devotion to one's family, the assumption of personal responsibility, finishing high school, working hard at a legitimate job—this must be a Republican—avoiding alcohol, tobacco, drugs and unwed pregnancies—I do not know that that sells very well on our side of the aisle—and improved diets and personal health habits; these changes and adherence to high standards of conduct will do as much or more to enhance health and improve the lives of the poor as any government spending program. A prize, Gail—whose two quotes are those?

Ms. WILENSKY. Why don't you tell me?

Chairman STARK. Can't you guess?

Ms. WILENSKY. I probably can, but why don't you tell me?

Chairman STARK. You wrote the first one, calling for subsidization to solve the problems of the low income and medically uninsured and Dr. Sullivan has been preaching the other one all over town. And what troubles me is that I think I can say that absent Dr. Sullivan's rather heart-wrenching suggestion—regarding family unity, teenagers are still being killed by guns. Do you remember the article in the paper on this?

Ms. WILENSKY. Yes.

Chairman STARK. Yet the administration adamantly opposes any kind of gun control. Now if you can tell me what family unity can do to stand up against an Uzi, I might back off on the idea of gun control. But it is just one time after another, just a lot of general rhetoric about commissions that might report something out but absolutely no proposals.

Now you wrote when you were in the academic community much better stuff than your speech writers and your testimony writers are writing now. At least you wrote about programs where we could do something. And it seems to me, if we can pay for this program, I would like a good reason to not provide to those who are otherwise uninsurable or those whose incomes would deny them access to general medical care. Why should we not begin immediately to provide these benefits to those people?

Ms. WILENSKY. This bill, in my opinion, is not doing that.

Chairman STARK. OK, can you have a bill for me in 30 days that will?

Ms. WILENSKY. I am not authorized to do that. You know that.

Chairman STARK. I will do it. I will authorize you. I will anoint you to do it right now. I will make you an honorary legislative drafter. The point is, we need some direction. To talk about celibacy and abstinence and prayer, that is not in the legislative arena. You know, you and I are not running for Pope. We are running for reelection. And we are also in the process of what has heretofore been a relatively nonpartisan sort of thing; we try to get stuff done for people who are sick, who hurt.

It is difficult to tell these people to wait for a commission when not one member of that commission or the Pepper Commission on which I served lacks health insurance. They do not know what it is like to be uninsured. They are sitting around, a bunch of predominantly wealthy, highly paid people tisk-tisking about the poor whom they have never seen, talked to and have no empathy with.

How are we going to get anything done?

Ms. WILENSKY. Well again, I am not going to tell you, because I think you know, and I have been on record too many times as saying that I think this is a serious problem. I do think it is a serious problem. I also believe that a very hard choice that all of us in the administration and you in Congress are going to have to face, is fundamentally in which of two directions to move; either putting substantially more money into the system or substantially restricting existing benefits, existing payment levels or existing subsidies. And those are difficult, painful decisions for all of us.

Chairman STARK. Let us assume that we are given a voucher from our Chairman. And he says, "Go ahead and close up these gaps," how would you do it? We do not have to worry about the costs. We are going to pay for it. The taxpayers are going to chip in and they are going to like chipping in. Let us presume. Let us pretend.

How do we do it?

Ms. WILENSKY. Well, I am not prepared to tell you precisely how I would do it. I am very concerned that we do so in a way which changes the fundamental incentives that I see present in the system that all push in the wrong direction. I am very much in agreement with an issue that I know you have raised which is the need for broader reform and not just a little bit of a change.

Again, I am not against a little bit of a change when we have really decided the direction we want to go in. What I am concerned about now is that all of the incentives in the system lead us to do more. I do believe that some of the issues that Dr. Sullivan has raised are very fundamental problems in our society. If we can find ways to attack them, it probably will have more impact on our well being as a nation than most of the fiscal things that I as an economist come up with.

But we need to impact expectations. We need to get people to stop looking at the health care system as a way to undo all of the untold damage they try to inflict on themselves. Medical malpractice is an issue that pushes more rather than less. You hardly ever get sued for doing too much unless you mess it up. You certainly

get sued for doing too little. And a reimbursement system which you are helping us try to change——

Chairman STARK. OK, but——

Ms. WILENSKY [continuing]. In terms of doing that.

Chairman STARK [continuing]. We do not know, as we sit here, neither you nor I know of a better existing system than Medicare. There is not one. Aetna's is not better. Medicaid is arguably worse. The military has higher cost per person. The Veterans' Administration is a disgrace in its inefficiency. So there is no other insurance system of any size that covers so efficiently and well and contains costs that we know of.

Now there may be something we could dream of but what other system is there that you could use as a model? There is not one.

Ms. WILENSKY. Well Mr. Stark, if you want to propose that what we need to do—and in fact I know you have discussed it since I have heard you—is to have Medicare available for some or all numbers of individuals on a cost-neutral basis, then I or somebody in the administration will tell you their opinion of how they feel about it. It will obviously be determined in part by the view of the administration on the role of Medicare vis-a-vis other payers of health insurance.

This particular bill is not cost neutral. It not only is not in any way self-financing, I believe that it carries with it a real additional danger. It provides one more encouragement to retire early. That is the last thing this country needs right now. Making Medicare available to early retirees is a reason to retire earlier and to bring their spouses with them.

Now I do not believe that you were intending to do that. But I believe the way it is written, that is what is being done. It is why, of course, the bill is so expensive. It brings to Medicare early retirees, some of whom have their own private insurance and some of whom have no insurance. It induces people to retire who might choose not to if they or their spouses would not have Medicare.

The impact of this is far greater than on health care costs. I mean, it is moving us exactly in the direction we would most like not to go right now.

Chairman STARK. I guess I could respectfully disagree or at least take the other side of that point. I am not sure that there is any empirical evidence to support that. And I am going to suggest that except for those who are so poorly employed or employed at such low rates that that does not hold water. Most of the issues we have had are the pilots trying to beat us around the ears because we force them to retire too early. I think people like to work. And if they are in well-paying jobs, it is in those last few years that their earnings are the highest, which will increase their retirement income even more by having more years at the highest level, particularly if they are in a private pension plan. I do not think we are dealing with those people who we want to keep in the work force. And, there are those who argue—I am not sure I agree with them—that one of the ways to solve part of our unemployment problem is to encourage early retirement. I am not suggesting that but there are those who do——

Ms. WILENSKY. There are those.

Chairman STARK [continuing]. In good conscience suggest that that might indeed be desirable. Many companies, to bail themselves out in the private industry are going out of their way to encourage early retirement with huge bonuses and buy-outs. I mean this is happening every day.

So I am not sure that the availability to a spouse or to a disabled person is going to be nearly as much of an incentive as, you know, a couple of hundred thousand dollars or a big cash out or a bonus which is going on. These may in fact put an early drain on the system. But I also do not support and I do not think that—well, let me ask this.

You indicate that the Medicare system is going broke.

Ms. WILENSKY. In 2008, right now.

Chairman STARK. OK. That is based on baseline projections from here on out, right?

Ms. WILENSKY. Including the changes that were made in——

Chairman STARK. Right.

Ms. WILENSKY. OBRA 1990, legislative changes.

Chairman STARK. Last year. OK, now in the time that you have been familiar with Medicare—is what, 6 years I have chaired this subcommittee and I think the 4 years before that—have we ever, either the administration or a Democratic controlled Congress, not reduced Medicare expenditures substantially below the baseline? I am talking $2 to $10 billion a year.

Ms. WILENSKY. We still have——

Chairman STARK. Have we not, for the past 10 years come in not less than $2 billion and I think the most was $10 billion below the baseline?

Ms. WILENSKY. Well the rates of spending that are included this year I believe are at least at or above the rates that are included in there. I mean——

Chairman STARK. What I am saying is that every projection that I have ever heard about the demise of the health takes into account a baseline which goes up with the market basket. And the fact is that that just does not exist. We have reduced—yes, I mean, I got it from my—this is what has happened.

Economists cannot give us credit for what we might do. But where we do cut and I am saying that to mean the administration even came in with $2.8 billion just now. You are talking about an agreement we had. They are asking me for $2.8 billion. I said, "OK, I will give you your $2.8 billion. Will you let me put it in this program?" I mean, I do not think it is fair.

Now that might only take us out to 2015. I do not mean to belabor the point, but give us credit for what we mutually have done every year for 10 years and that is take a big swing at that baseline increase. You are going to get Jimmy Roosevelt back after you if you keep scaring the seniors into thinking that Medicare is going broke sooner than it might.

So I wanted to say I am not sure that is always a fair rap for both sides, I think your staff and my staff have done an outstanding job to hold those costs down every year. It is hard to write into law. We have been fairly creative. But the 2008 date assumes that there will never again be a reconciliation bill.

Now, I mean never? Do you want to bet me $1 either way? I will give you $1 for each year in which there is not a reconciliation bill if you will give me $1 for each year in which there is. I do not know where that takes us but I think reasonably we could go beyond 2008.

I guess I just want to summarize and then I would like to recognize Mr. McGrath. It is apparent that the administration does not intend to present a program, certainly in this year. And you know we can. Thus, I must criticize wherever in the administration it has been decided not to present an adequate domestic program. Health is bad enough but they are not going to have one in education. We are not going to have one on the environment. And they are not going to have one on energy policy. The only thing we hear about is the Biblical admonitions as to how we should live a better lifestyle.

That is okay. We do not have much money to spend under the budget agreement. But then why not let us where we can find minor incrementalism though it may be adjustments, small groups that we can add with the stipulation that we absolutely have to pay for it. I know what the rules are. We are good at it here. We could raise this money so quickly by taking up the cap on HI. I mean, there are a dozen ways we could raise the $5 billion, assuming you are right on that number.

And you might say, "Well this is not the group that needs it more than others." I am just suggesting to you and you well know this; we are not going to raise Medicaid because that group of poor people have absolutely nobody lobbying for them or against them. They are powerless. The senior citizens have a good bit of power. Children are building a constituency. We might do it with children or seniors and I will bet you the AARP would get right in line if you and I agreed to do something with children today who are uninsured, at a cost of $5 or $10 billion. That is fine with me.

But where can we find a program that we can fund? Do not kill the better with the best because the best is not going to be around until after the 1992 election. I am just saying I will promise not to beat up on prayer, abstinence, and celibacy anymore, if you will promise to say maybe we can, where we can make a small bit of improvement in the system, we can go ahead and do it. That is all I would ask.

Mr. McGrath.

Mr. McGrath. Thank you, Mr. Chairman. Dr. Wilensky, welcome.

Ms. Wilensky. Thank you.

Mr. McGrath. I'm sorry I wasn't here to hear all of your testimony. I know basically what you had to say. I read the testimony before. We were in the back room meeting with the ambassadors of the Andean countries talking about some treaty for some trade with them so that they can get rid of their drug trade.

I'm interested, frankly, in the thrust of this bill. Obviously, our chairman has pointed out some of the pitfalls, as well as some of the benefits. One of the pitfalls, of course, is how do we pay for it. Very frankly, I don't see us, as easy as he says it is, raising the wage limit past the $125,000 that already exists at this particular point in time. We just raised it from $53,000 to $125,000 last year.

I'm not sure there's a heck of a lot of stomach to raise it even further, but I'll leave that up to him.

Assuming something like this is a good idea on the policy side, in order to obtain that $5 billion fee that you quote, what kinds of cuts would we have to look at in other functions that are financed out of the HI Trust Fund? The proposal by the administration this year cuts $25 billion extra out of Medicare over the next 5 years, with 60 percent of the 1992 cuts coming from indirect medical education and slipping the cost update date from——

Ms. WILENSKY. October to January.

Mr. MCGRATH. October to January of this year. What other kinds of things would get us that $5 billion that could perhaps put this in contrast to what the chairman has indicated?

Ms. WILENSKY. Well, I'd like to question, assuming this is good policy, and you may have been out of the room when we were discussing whether it is an issue that I really believe very strongly? I think there are incentives in this bill to increase the number of early retirees. Now, we can disagree and that certainly happened on other issues.

I do believe there is empirical evidence available that the age at which retirement benefits are available does impact the age at which people retire. Now, it doesn't encourage retirement for everybody. Obviously, a lot of people in their mid-sixties have all of their well-being and their identification attached to their job. They fight very hard to keep their job. It is not only income, but it's their whole identification in society.

Nonetheless, we see and have seen, over the course of a long period, increasing numbers of people who retire early. This is very unhelpful. It's unhelpful in the sense that we have a low birth rate and will have smaller numbers of people entering the labor force. We have larger numbers of people who are living longer. Because they are living longer, they are also impacting our Social Security and our Medicare system. We can debate about whether or not 65 is a magic age. It is the traditional age we have used. Although, as I mentioned, Social Security is now edging up to 67.

Moving eligibility for Medicare, which is heavily subsidized in part B and substantially subsidized under part A, to early retirees between 62 and 65 will, I believe, tip some people into retirement. It moves us exactly in the direction, I believe, as a country we do not want to go.

We want to keep these people as part of our labor force. They have important skills. I really believe that aside from the enormous amount of money, $5 plus billion the first year and $24 billion over 4 years, this bill truly contains policy that we do not want. I don't know that it was intended to do that. I believe it really does contain a movement we don't want.

Chairman STARK. Would your objection, if the gentleman would yield for just a second, go away if we had a universal coverage health insurance available? Then your objection would be dealt with, correct?

Ms. WILENSKY. That objection would be dealt with.

Chairman STARK. Yes. I mean, because then everybody—there would be no incentive there.

Ms. WILENSKY. To switch.

Chairman STARK. Thank you.

Mr. MCGRATH. Now, maybe we can get back to my question.

Ms. WILENSKY. OK. I just didn't want to accept that this bill is good policy. I think this is seriously not a good policy.

Mr. MCGRATH. You have every right. What kind of cuts to Medicare would be required in order to finance this bill should no tax increase for this purpose be attainable?

Ms. WILENSKY. The indirect medical education proposal that has caused substantial consternation to, if not yourself, I know some of your colleagues--

Mr. MCGRATH. Myself included.

Ms. WILENSKY [continuing]. Is estimated to raise $1 billion in 1993. It has been our interest not to do very much on the part B side at the present time because we are attempting to change the whole way we go about paying for physicians.

Last year, you will recall, the administration had proposed $5 billion worth of changes in parts A and B, to which we had very major responses of how much that would hurt the program. In fact, the whole budget process came up with only somewhat over $3 billion of changes. The $5 billion is substantially more than the almost $3 billion in changes the administration has proposed for fiscal year 1992. It's more than half again what the chairman, Mr. Rostenkowski, has declared is not even relevant for discussion.

So, $5 billion in the Medicare program, particularly if you do not want to do major change to part B, is hard to find. I can give you a series of proposals that will knock out $500 million or $200 million. But it is hard to get that kind of money to $5 billion.

Mr. MCGRATH. Let me also point out to the chairman that he made a statement that Medicaid won't be increased because there's no constituency.

Chairman STARK. There is a constituency, they just don't have any power.

Mr. MCGRATH. I think your premise is correct. But, I think, the reason is incorrect. My State, which has opted for every option of Medicaid since the beginning, is desperately looking for ways to scale back. Not so much because they are heartless, but because it's costing a lot, not only at the State level. In New York, one-quarter of the share is picked up at the local level and directly through the levy of property taxes. In my county, the social service district where I live, the second largest expenditure in the budget is the 25 percent share of Medicaid, and that's only after the police department.

One further thing that sort of is inconsistent about this, even though we've had testimony, Dr. Wilensky, from others that by picking up some people in the younger age group, younger than 65, it might eliminate some of the 33 million people that are uninsured at the present time.

Ms. WILENSKY. That's correct.

Mr. MCGRATH. It seems to me that it's somewhat inconsistent in terms of what we did in 1983 by increasing by a month the age of retirement and then all of a sudden say that you can have 60. But, in addition, we are desperately trying, some of us on the committee are desperately trying, to eliminate, the wage limitations for Social Security recipients between the ages of 65 and 70. This would allow

these individuals to keep working, and they can give us the benefit of their expertise. This would enable the healthy ones to continue, those who want to, to continue without having any impediment.

While I understand the thrust of the bill in terms of trying to cut into that 33 million, at least that portion of them that are in that age group that are either underinsured or uninsured, it seems to me we're being a little bit inconsistent in other thrusts of other policy endeavors that we are looking at in this committee.

So, while I certainly appreciate your testimony, I'm looking forward to hearing that of the other distinguished people that we are going to be hearing from today. I just would point out that I'm 49 years old and I'm closing in on 50, and I'm getting a little worried. I'm starting to get mail from the AARP telling me I should join. My wife is pregnant and ready to deliver any day now and I think that's pretty inconsistent, too.

Thank you.

Ms. WILENSKY. I believe this is inconsistent with what was adopted in 1983.

Chairman STARK. Mr. Moody.

Mr. MOODY. Thank you very much. I'm sorry I had to be out for a bit. Just alert me if I ask a question that has already been asked and I'll skip on to something else. You said in your testimony, in your written testimony, that by the year 2000, the HI fund will be insolvent.

Ms. WILENSKY. Our present projection is the year 2008.

Mr. MOODY. You said by the turn of the century in your testimony. OK. 2008.

Ms. WILENSKY. It's 2008. It went from 2005 to 2008 by increasing the HI tax limit from $53,000 to $125,000, which was done in OBRA.

Mr. MOODY. Right. Maybe we should lift it still higher to keep this number moving out as we get closer to it.

Ms. WILENSKY. Well, one of the things that obviously, happens as you lift it higher, you have less kick. I would have actually guessed that the kick of going from $53,000 to $125,000 had been a lot bigger than it was. The problem is we're going into deficits fast because of the increasing number of beneficiaries. We're not quite at the baby boomers. The baby boomers hit in 2011, when the first of the baby boomers start to retire. But the trust fund outlays are so large that the income from that additional HI tax amount can't begin to stem the tide.

Mr. MOODY. Right. Anyway, my point is that your statement is that it hits insolvency. The lines cross into the red ink at 2008. That assumes, 16 years from now, no structural change in the program.

Ms. WILENSKY. That is correct.

Mr. MOODY. Earlier on, on page 4, you criticize 1444 because it takes an incremental approach without any clear vision of an ultimate goal. Those two points that you make cry out together and plus other factors cry out for the administration giving us an ultimate goal, a clear vision, and a set of structural changes that will head off this financial catastrophe.

I don't see anything like that happening and I may be repeating what others have said, but it's one thing to nitpick this particular

bill. Obviously you can sit here and criticize the fiscal float. But that the system, if it rests on status quo, if it rests on the structure remaining exactly as it is now until year 2008, will bring about a lot of problems, more problems than just this bill will bring about.

We have massive, unbelievably massive, deficits in the health care system of which this bill is rather a minor part. So, to criticize this bill without offering the way to avert a much bigger financial catastrophe seems to be focusing on a couple of trees and not the forest.

Ms. WILENSKY. Well, we did talk about this. But I will be glad to respond.

Mr. MOODY. I apologize.

Ms. WILENSKY. I am not against incrementalism and I think that when we decide what we want to do, we will probably do it in an incremental way. That is typically how we do things. I am also not going to say that I don't think that the issues raised in both coverage and in providing incentives and/or controls to restrain health care cost increases is not important. I think it is important. I think all of you on the committee know I believe that.

We in the administration are struggling with these issues. I do not believe that you will see a bill this year. Among other things, this is a very shortened legislative session. But we are working on it. I hope later this year that there will be recommendations from the department that will go to the White House. I do not know whether that means that there will be an administration position either at the end of this year or early into next year, 1992 as I certainly don't have to tell you gentleman, is an election year and that tends to take on forces of its own.

We need to be sure that when we move incrementally, the changes are likely to be those that ultimately we want to adopt. There are at least two issues that are raised here. One has to do with whether or not extending Medicare to populations that have traditionally not been covered under Medicare is something we want to do. Is that something that we are likely to want to do in the future? That is a separate issue, and I'm not authorized to comment on that.

The other issue is that this particular bill, I think, is especially unhelpful because it encourages early retirement by making available subsidized Medicare coverage to people in the 62 to 64 age range. It exacerbates a problem that has nothing to do with anything that I'm aware of that Mr. Stark has been involved with in other legislation.

It is something we're trying to undo through Social Security.

For the health of both the society and individuals, we need, if anything, to think about how we can keep people as part of the work force. We don't need to do things, both in terms of financial incentives and other incentives, to encourage them to retire early.

As you probably know better than anyone else on the committee, econometric and economic evidence is always a little murky. But there is some evidence that the age at which benefits are available does have an impact in terms of retirement decisions. Therefore, aside from the issue of trying to address this very important social problem, the particular way the bill would do it is not helpful.

It's very expensive, over $5 billion in the first year, and it leads us into a position that I believe we absolutely do not want to be in, which is to make it more likely rather than less likely that workers will take early retirement.

Mr. MOODY. That feeds right into my next two questions. One is what is the empirical evidence? We all know what the direction of the gravitational pull might be on any change of incentives. You know, if you move Pluto slightly, there's a slightly different pull on the earth. If you throw an orange into the air, all the stars are just a minute amount. We know that's true. But it's so negligible as to be unimportant.

My question is, what is the empirical evidence? How strong is the force? I'm a believer in supply-side economics, too. But I always question whether or not the force is strong enough to have the effects alleged. So what is the empirical evidence?

Ms. WILENSKY. OK. Well, I'm a public finance economist. I'm not a labor economist. So I'm about to get a little bit out of my area. We will obviously be glad to summarize for you what, in fact, the literature shows in terms of how big the effects have been. I asked to be briefed on this since it perked my interest when I was preparing for this hearing.

My understanding is that there have been a number of studies done, including as it turns out, by Mr. Boskin in his prior days at Stanford, but also by people like Tony Poleckio and Richard Burkhauser, and a number of others that have indicated that it is not just the amount of benefits that is available, but also the actual timing of when that is available that impacts on retirement decisions. I cannot tell you whether it is regarded as a big impact or a medium impact, or a small impact. But I'll be glad to provide that information.

Mr. MOODY. Well, if the impact is substantial enough to generate the policy recommendations or statements you've provided to us, then, I guess, the logical extension of the argument is that we should start raising the age of eligibility for Medicare in order to respond to those very same incentives. In fact, on page 3, you say, "Changing the age of eligibility is appropriate considering the increase in life expectancy." Is that the policy that the adminstration has, that we should start raising the eligibility year above 65? I'm using the same logic.

Ms. WILENSKY. No, I am——

Mr. MOODY. For financial solvency reasons that you're using to say we shouldn't lower it.

Ms. WILENSKY. The administration, to the best of my knowledge, has not taken a position on this issue. I will obviously be glad to ask whether there is any willingness to consider that. I don't think there has been one. There was a recommendation from the 1983 Advisory Council on Social Security that, indeed, the age for Medicare eligibility should be increased to match the Social Security increase that we are now in progress of accomplishing.

It is my understanding, and I actually did one of the research studies that was involved with this issue, that because there was so much debate about whether people were living longer and healthier or just living longer and so much dispute about whether the onset of disability was occurring later, or whether it was just occur-

ring at a lower level, that there was no firm agreement in terms of a policy move.

What I do believe is that this is moving in the wrong direction. Do we want to have more people retiring before the age of 65? I do not believe that we want to do that. Will this influence the retirement decision? I think the answer is yes. Will it be a big influence? That I can only give you the information that is available.

Mr. MOODY. But that's the crucial question. What's the magnitude of the influence? If it's negligible, then we have to focus on the other issues like do we want people covered who are near 65 for other sets of reasons? On the other side, if they could be covered free, it would be great. They can't be covered free, so then we begin to weigh the magnitude of these effects. If we don't have the magnitude or one of the crucial effects that's used, then we really don't know whether the policy recommendation makes any sense or not.

Ms. WILENSKY. I don't dispute that having the magnitude would be helpful. It is probably consistent with what we have been observing—a large number of people are retiring, are not in ill-health and are retiring before the age of 65. Their lifespan is growing and not shortening.

Mr. MOODY. My other—and I will be brief—line of questioning is this; is it cost effective for society, not for the Medicare trust fund, but is it cost effective for society for someone to be covered? The reason I am asking is that you know, again, using the incentive structure as a point of reference, if people are covered do they come in earlier? Is more emphasis placed on preventative care? Do people get checkups, if they are covered for those? Do people tend to intercede earlier? Does the system bring people to its attention sooner if they are covered? Is it cost ineffective to not be covered?

Now if that is true—assume it is cost ineffective not to have insurance and most employers who are loyal to their bottom line and who can swing it financially believe it is cost effective to have their workers covered. They do not do it out of humanitarian reasons. I, as an economist, believe that people follow their financial instincts that are in their self-interest. General Motors and other companies have their workers insured because it is cost effective to be insured for the reasons I have just outlined.

If it is cost effective to be insured, as most industrialized societies believe it may not be cost effective in solvency terms for the Medicare trust fund. But perhaps for society, Dr. Wilensky, it is cost effective to insure people who are between 62 and 65 because we will end up paying the bill somewhere else.

If someone 63 who is retired or does not have coverage in his or her work is not covered, they get covered by going into the emergency room. Then the hospital tries to figure out how to pay for it and we end up paying it in our property taxes or in a variety of other ways through cost shifting to private pay.

It is my gut belief, and please correct me, is that it is not cost effective to uninsure people.

Chairman STARK. Would the gentleman yield for a moment?

Mr. MOODY. Sure.

Chairman STARK. Would you just amend this question to ask the good doctor if she did not write an article that made this very same point some years back in her career? And then go ahead.

Mr. MOODY. Thank you. I will be happy to include that in my question. And it is more of a speech and I do not mean to go on and on. But if you believe it is cost effective to insure people for society, not for the Medicare trust fund, because we have got the Medicare trust fund and then we have all the other ways of paying for things and all the cost shifting—we are all aware of cost shifting—is it really not socially cost effective to insure people between 62 and 65? That is the question I would rather focus on rather than just purely on the solvency question.

Ms. WILENSKY. I am not going to tell you that I do not think dealing with the uninsured is a serious problem. I do not really know whether it is cost effective per se to have people covered by Medicare or not. I do not think we have a very good sense about what it means——

Mr. MOODY. No, insured or not, wherever they——

Ms. WILENSKY. What it means if people delay seeking care—we know that people who do not have insurance coverage do use medical services. They appear to use less. As you gentlemen know, our knowledge of what the real implications of not doing something at various points in time in the medical sector is not very clear. There are a few medical interventions that we know make a big difference—monitoring for high blood pressure, prenatal care, immunizations. We do not have a lot of knowledge about what happens if you do not use health care at various points, if you delay bypass surgery, if you delay various other kinds of medical care.

But there is no question that not having health insurance coverage leads people to behave differently. It puts them at risk financially and it puts them at risk medically.

Mr. MOODY. And it puts the society at risk financially.

Ms. WILENSKY. Whether or not we end up paying more or less or differently we know. But I think there is a lot of concern as to what it means to be uninsured.

The problem is that this bill deals with all sorts of people and it deals with them in a particular way. I am not going to tell you that I think that the issue of the uninsured and the issue of cost increases are not serious social issues. Again you were out when I said that it is difficult for this administration and it is difficult, I believe ultimately or it will be, for Congress to face the choices—either putting in substantially more money in the system or seriously redirecting benefit levels, payment levels to providers or existing subsidies. I do not have to tell you gentlemen who need to run for election—I do not—that any of these choices are very painful. I only say that these are not easy choices.

I think the kinds of moneys that would be required by this bill, $5 billion in the first year in our actuaries' very preliminary estimates—and I do not want to pretend they are more than that—and $24 billion over 4 years is a very big amount of money to take on an issue in a direction which we have not decided is how we want Medicare extended beyond the nonelderly population. In addition, it raises all of these retirement questions.

Now you can come back and say, "Well, if you do not like this, come up with your own bill," and the answer is I do not believe that the administration is going to between now and the next couple of months. But as you well know, we are working on the issue. We are trying to come to some agreement about how to proceed. I cannot tell you in any sort of clear conscience that come the end of the year or the beginning of the next year the administration will have a position on what to do because I do not know.

I know we are working on it and I know it will go forward, but I do not know what the outcome will be.

Mr. MOODY. Right. Well, I do not mean to badger you or anything. I just want to raise these issues and I will let you go. But just when you figure out, when you do come in with a firmer estimate on the $24 billion over 5 years, can you try to come in with an estimate of what it will cost society not to have people of those same cohort not insured for those 5 years?

Ms. WILENSKY. Well, we will do our best.

Mr. MOODY. I mean, that should also be in the calculation to make an intelligent policy decision.

Thank you.

Chairman STARK. I thank the gentleman.

Mr. Levin.

Mr. LEVIN. Thank you. I missed part of the colloquy, but I think what I heard—I am shuttling between two hearings—has been most interesting and might be characteristic of what went on before.

I was going to ask you one question. You have already answered it, maybe. I understand the problems with this proposal. I was going to ask you to give me a clue of the options that—the alternatives that might exist—without indicating what direction you are going in. What are the options if this one is not on balance an adequate one?

Ms. WILENSKY. Let me give you some of the issues that get raised as you think about the uninsured. You basically have two different populations although this one interestingly enough crosses between the two in a way that we are going to have to watch out for. The two populations are those who are part of the labor force and those who are not.

For the most part, those who are not part of the labor force are not workers. Substantially, nonworkers tend to be, although they are not entirely, low income people, the lowest, the poorest of the populations. I think there you can look at different ways to bring in very poor individuals through some subsidy. The kinds of questions you get into is what level of government and what level of subsidy are you talking about and how should that relate to our existing Medicaid program?

With regard to the working population, the kinds of questions that you first have to address are are you going to fundamentally stay with employer-provided insurance through the tax subsidy system as the mainstay. And if so, are you going to try to fill in the other workers by more incentives or are you going to try to start putting some sort of heavy foot on either in terms of soft or in terms of hard mandates, the play-or-pay so-called strategies or mandated benefits?

One problem this bill raises is that people might not always stay in the categories they start with. It actually raises this issue that as you try to worry about workers and what you might do, you raise the concern about whether you make it more difficult for new small businesses to remain financially viable during their early periods. This is still the source of most of our new employment in this country. Also, will you do something about decisions for people who might be workers to become something other than workers depending on what the coverage looks like.

There is also the problem of those who are currently working who might be thinking about retiring. You begin to raise the issue that not only does it pick people up at the point you look at them, but you have to look very carefully at whether or not it leads to other incentives.

Some of the policy options go much broader in terms of whether you are putting the subsidy on the individual rather than on the employer. For example, our current tax subsidy is provided to the employer, but the worker cannot take it with them. If the employer does not provide health insurance coverage the worker does not receive the tax subsidy.

We are looking at the same sets of options which people, myself included, have raised to decision makers over the past 5 or 10 years. Occasionally we come up with some new spins or some new options, but I do not know that the fundamental sets of choices are radically different than what they have been in the past.

Mr. LEVIN. That is an honest, I think, assessment. So you are saying—I do not want to put you too much on the spot—but you are saying at least at your level there is serious consideration being given to, for example, a combination in response to this problem of expanded Medicaid and employer mandates?

Ms. WILENSKY. They are strategies. I think this administration has made its general position with regard to employer mandates well known. But obviously if we are going through——

Mr. LEVIN. Well if you exclude them, I mean, what is left?

Ms. WILENSKY. Incentives, requirements of other sorts on employers.

Mr. LEVIN. Thank you.

Ms. WILENSKY. It really is a question of whether the subsidy goes to the individual or the requirement is on the employer.

There are clearly people who believe that if you do not require employers to provide health insurance that you are going to always miss a lot of people. The issue of how much and how far can you go with other than hard mandates is an issue to which there is some debate.

Mr. LEVIN. I mean, is there a chance—my last question along these lines and altogether—do you think there is a chance that by the spring of next year that there will be no proposal forthcoming?

Ms. WILENSKY. Well obviously I think there is a chance. I just do not have a sense about how good that assessment is in 1992. I am quite sure that by the end of this year, information, recommendations and work from the Department group will go to the Domestic Policy Council and the White House.

Whether the administration will come forward with specific legislation or a general program or choose not to make this a specific

issue, I am really not in a position to know that. Because a position has simply not been taken in March of 1991 I think to some extent there is not anybody who knows the answer to when or what will be available. But I certainly can say I am not the person who knows the answer to that.

Mr. LEVIN. Thank you.

Chairman STARK. Thank you and let me just comment on that because it is a question here of what we might be able to accomplish in this year. Without prejudice, I would submit to you that this subcommittee and Mr. Darman and yourself and Dr. Sullivan could probably work out a bipartisan agreement. But if you add people like Sununu or Rev. Jesse Jackson from the other side into the equation, we would never come to any kind of political compromise.

As for the Pepper Commission, we fought among ourselves, and the Republicans split as to whether we should have an employment based system or a social system. What I am saying is that we have this wonderful opportunity of a year or so to clear out some underbrush and perhaps see if we cannot find some areas wherein the people who will argue more on the technical issue than on the political issue go ahead and say, "Look, we might as well make a few tentative decisions about things like what do we do to cover children?" An employment based system, I think everybody feels, is a relatively inefficient way to figure out how to cover kids through the employment system.

Maybe we can come up with an accounting system for children, to determine who is insured and who is not and who ought to get covered. But what I would say is while we wait for the go in the form of some kind of commission to bring the tablets down from the mountain, why don't we, as you suggested in the closing part of your testimony, rather than work on a strategy which is in neither the province of either of us, why don't we try and find some areas that we can get something done, as insignificant or small as those things might seem to the world at large.

I think we both know some areas where we might make some improvements. In addition, I have urged the AARP and others to express their opinions. But what I am afraid is going to happen to us is that the Democrats who control both Houses of Congress and the Republicans who control the administration are not going to agree among themselves, and some coalition is going to form and we aren't going to be invited to the party.

You may get big business along with big labor suddenly deciding to go in with—throw in with the AARP—and they say, "Hey, we do not need you, administration; we do not need you, Stark, and your committee. We have enough clout here to run this one through." The result will be a system that neither of us like. I really have the sense that when the American public decides that both of us, whether it is the adminstration or the Congress, has not done their work, they are going to grab the first acceptable program that comes down the pike and we are going to be wondering where we were when all this was being planned.

So my sense of urgency is that there is nothing new since 1963 when they started this debate. They almost included everybody in Medicare then.

I am reading through your articles now. What you said makes some good sense. You are a little more conservative than I would be but it is amazing what a Ph.D. does for people.

So I am just saying why cannot we find some areas where we can make some minor accomplishments like nursing home reform, for instance.

All right. Thank you very much for being with us this morning. I appreciate it. I look forward to working with you until the commission hatches whatever they are gestating right now.

Ms. WILENSKY. Thank you, Mr. Stark.

Chairman STARK. In our next panel, we are pleased to welcome three prominent representatives of the national senior organizations.

John Rother is the director of legislation and policy for the American Association of Retired Persons.

Dr. Arthur Flemming is the chair of Save Our Security Coalition. He was Secretary of the Department of Health, Education and Welfare from 1958 to 1961.

And Mary Gardiner Jones is a member of the Older Women's League, affectionately and commonly known as OWLs, and serves on their board of directors.

I would like to welcome all of you to the committee and ask if you would like to summarize your statement? Since I am here alone, I will read your prepared testimony more quickly than you could read it, so maybe you would like to expand on it for the record. Without objection, your testimony will appear in the record in its entirety Once we have heard from each of you, I will ask questions. I will give you a chance to expand on your views at that point.

Mr. Rother, would you begin?

STATEMENT OF JOHN ROTHER, DIRECTOR, DIVISION OF LEGISLATION AND PUBLIC POLICY, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. ROTHER. Thank you, Mr. Chairman.

My name is John Rother. I am the director of the Division of Legislation and Public Policy of the American Association of Retired Persons.

We prepared several documents for the committee this morning. One which I would like to call your attention to is excerpts from many of the thousands of letters that we have received from our members who would be helped by the legislation you have introduced, people who are denied health coverage because they are forced out of a job prior to age 65, because they are disabled and must wait 24 months for Medicare coverage, or because their spouse is Medicare eligible but they are not. I think anyone who is reading these kinds of letters or speaking to people who are in these situations realize that there is a whole different dimension to this issue than we have discussed so far this morning.

Much of my prepared testimony goes to some lengths to provide data relating to the need of this population, and in that respect I think I would like to take issue with Dr. Wilensky's testimony. She

said that it is unclear why we should target the near-elderly, because they did not exhibit a striking obvious need.

On the contrary, even a casual look at the data that we put together would show that that is not a very carefully considered statement. The near elderly—people between the ages of 55 and 65—face very severe problems with health insurance. Those who do not have that health insurance are also those who have the greatest health risk, in terms of being in the poorest health. And, paradoxically, even though they have the greatest need, they only utilize the health care system approximately half as much as people with insurance.

So, when you look not only at the fact of lack of coverage, but also look at the need, who these people are and what it is that they face when they need health insurance, I think it is a very severe situation and one that does deserve priority attention.

Before going further on that, I want to take issue with one other thing that Dr. Wilensky emphasized, and that is the issue of retirement incentives and whether we should even be talking about changing eligibility for Medicare, because of our concern that people not be encouraged to retire before the age of 65.

Mr. Chairman, the fact is, today, at the age of 65, only 25 percent of men are still in the labor force, 15 percent of women; at age 62, it is 40 percent of men and 25 percent of women. You know, for the 60 percent of men who are already retired by the age of 62, and for the 75 percent of women who are already retired at 62, it is not a question of incentives, it is a question of a crying need: how they can protect themselves from the costs of health care, and how can they assure access to a health insurance system.

So, to put this in terms of incentives, is simply a denial of reality, and is certainly punitive. I am in favor of incentives for continued work, but this is not an incentive. This is capital punishment for someone who may have no choice about the decision of whether or not to retire.

I think it is also fair to say that the premise of age 65 in Medicare was that the private employment system would take care of the health insurance needs of people up until age 65 and the result, as we see today, is that that is not happening and the system is breaking down. The COBRA provisions and State risk pools are not adequate to deal with that situation.

I would just like to highlight a couple of facts, and then go to our conclusion. We find that about 13.6 percent of persons between the ages of 55 and 65 have no health insurance today; about 11 percent of those people lack health insurance for a full year, according to our 1987 data, which is the most recent available.

Why do they lack insurance? Three reasons: No. 1, low income; No. 2, they are no longer connected to the workforce; and, No. 3, they have preexisting conditions which preclude them from purchasing insurance at a reasonable rate.

Health status for this group is much poorer than for the younger uninsured group. As a matter of fact, for people who are in the age range of 55 to 65, they are six times as likely to have poor health or report themselves as being in fair or poor health, compared to younger adults, so the need is great.

I mentioned the fact that they only utilize health services when they lack insurance at about half the rate of others who have health insurance. The disparity is striking and cannot be explained due to waste or other self-induced discretionary factors. The fact is that these people are not getting the services they need and as a result we, as taxpayers and employers, are paying a greater price in larger health expenditures later on. There are also the human costs not providing the insurance when it is needed.

AARP believes that the legislation which has been introduced, although we have not had time to study it in detail, does present an attractive incremental option for coverage. Our first preference would be a more comprehensive approach that covers people of all ages, particularly children, as well as seniors—an approach which would contain cost containment incentives, as well as long-term care coverage.

Lacking that, however, I think there are a lot of reasons to look to the Medicare program. It is a very efficient program, it is very popular, and its benefit package is relatively complete.

Finally, Mr. Chairman, we have brought with us some empirical data runs. The material with our testimony shows some of the costs for the entire age group, age 50 to 64, of expanding coverage. I also have with me a similar run that shows the costs of simply lowering the age of Medicare to age 62—about $5.7 billion a year additional costs. But there would be offsetting savings. Employers would save about $2.5 billion a year; State and local governments would save $1.2 billion a year; and private households, you and I, as families, would save $1.9 billion a year.

So, there is additional cost to the program, but the societal benefit is terrific in exchange for the protection of families, assistance to employers, particularly small businesses, and some fiscal relief for State and local governments.

As my remarks today and my written statement indicate, AARP believes there are some important reasons why a proposal along these lines should be considered. We would be happy to work with the committee in the future in this regard.

Thank you.

[The prepared statement and attachment follow:]

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STATEMENT OF JOHN ROTHER, DIRECTOR, DIVISION OF LEGISLATION, AND PUBLIC POLICY, AMERICAN ASSOCIATION OF RETIRED PERSONS

A. INTRODUCTION

Good morning. My name is John Rother. I am the Director of the Division of Legislation and Public Policy of the American Association of Retired Persons (AARP). Thank you for the opportunity to discuss the unique health care challenges faced by Americans--particularly the near elderly.

As a nation, we can be proud of our achievements in health care, but these achievements are being diminished by our failure to guarantee all citizens access to basic acute and long-term care, and to control escalating health care costs. Unless we can achieve comprehensive reform of our health care system, we will likely see further growth in the size of the uninsured and underinsured populations as well as continued escalating costs.

Undoubtedly, the phenomenal rates of increase in health care costs represent the most substantial barrier to access, and affect all age groups and income brackets. Those with and without insurance are at risk: the worker whose children are uninsured because of the lack of dependent coverage; the young adult who cannot buy health insurance due to a previous health condition; the couple struggling to raise a family, while faced with the extraordinary expense of long-term care for their parents; the small business that cannot afford or is denied health care coverage for its employees and dependents; and the retiree not yet eligible for Medicare who is unable to obtain affordable health care. Until each of these shortcomings is seen as part of a common problem, reform will come slowly, if at all.

AARP is committed to the goal of reforming our health care system so that all Americans--regardless of age--have access to affordable, needed care. If we are to reach this goal, comprehensive reform of our health care system must become a national priority. Toward this end, AARP has adopted principles (included at the end of our written testimony) to guide reform of the health care system. The Association believes that to achieve meaningful health care reform, Congress must establish a blueprint--the broad architecture--of a reformed system that reflects these principles.

Our lack of consensus on the nature of our health care problem has resulted in a piecemeal or "band-aid" approach toward reform. Year after year we have added levels of complexity to our already fragmented health care system, resulting in perpetual cost shifting and increasing administrative costs. As we have attempted to control costs in one program, we have shifted the burden to another. Efforts to control provider costs have only increased the lack of uniformity in reimbursement practices among public and private payers and further contributed to the problem of access. The lesson is clear: we need to develop a consensus around a comprehensive health care reform plan that assures access for everyone and that does not differentiate provider reimbursement by source of insurance. Failing this, we will not be able to achieve real cost control.

AARP understands that incremental steps may be necessary to move us towards a comprehensive health care system. We recognize that there are particularly vulnerable populations that could benefit greatly from immediate, targeted changes in the current system. Our testimony will begin with an assessment of the vulnerability of <u>one</u> of these populations--the near-elderly--in terms of: (1) health insurance status; (2) health status; and (3) pattern of health care expenditures/utilization.

After reviewing several targeted strategies for providing health insurance to the uninsured, we will focus our remarks on the proposal under consideration by this Committee to extend Medicare coverage to specific groups within the 62-64 year-old range. Finally, we will present some original data on the estimated costs and impacts of including all persons ages 50-64 in the Medicare program.

B. HEALTH INSURANCE STATUS, HEALTH STATUS, AND HEALTH CARE EXPENDITURES/UTILIZATION OF SERVICES: WHO IS AT RISK?

I. Health Insurance Status: Who Is At Risk?

Notwithstanding annual national expenditures for health care in excess of $600 billion, about 16 percent of the nonelderly U.S. population (or about 34 million individuals), and 1 percent of the elderly population (about 300,000 persons), lack health insurance from any source. Those with the greatest likelihood of being without health insurance include: the poor and the near-poor, regardless of age; young adults and children; and members of minority groups.

Results from the National Medical Expenditure Survey (NMES) indicate that, by any measure, the poor and the near-poor, regardless of age, face the greatest risk of being without health insurance during the course of the year; nearly one-half of them lacked insurance at some point in 1987, and more than one-quarter lacked insurance all year. Young adults between the ages of 19 and 24 are also among the most likely to be uninsured. About 40 percent of them went without health insurance at some time in 1987, and 20 percent lacked health coverage for the full year. Children face a significant likelihood of being uninsured; nearly one quarter, or 16.4 million, lacked coverage for all or part of 1987. Minorities face a high risk of non-coverage, as well. In 1987, 30 percent of Blacks and more than 40 percent of Hispanics lacked health insurance.

Although the near-elderly, that is, persons between the ages of 55 and 64, face a much smaller risk of being uninsured, their numbers are not insignificant (13.6 percent uninsured, according to the NMES, and 11 percent uninsured, according to estimates from the Employee Benefit Research Institute (EBRI) using CPS data).

Sources of Health Insurance For The Near-Elderly

The 1988 Current Population Survey (CPS) indicates that nearly 80 percent of all 55-64 year-olds had some form of private health insurance coverage in 1987. Employer-provided health insurance was the dominant source, accounting for just over 80 percent of private coverage.

Although individuals ages 55-64 are about as likely to have employer-provided coverage as are younger persons in general, they are significantly less likely to have such coverage than are persons ages 25 to 54 (65 percent and 73 percent respectively, according to the first round of NMES interviews). This finding is a function of several factors. First, only about half of persons ages 55-64 are in the workforce, compared to about three-quarters of all working age individuals. Lack of employer-based insurance among the near-elderly often derives from a transition out of the workforce. For example, with increasing age come increasing health problems, which may, in turn, force an individual to stop working. Early retirement, for health or other reasons, may result in a gap in health insurance coverage until a person reaches 65 and becomes eligible for Medicare. Lay-off or termination would also create a gap in coverage. A younger spouse who has relied on insurance coverage through his or her older spouse's employment may lose coverage as the older spouse leaves the workforce and/or gains eligibility for Medicare. Other factors that pose a potential threat to older adults' employer-based insurance coverage include divorce or the death of a spouse.

Second, a disproportionate share of the near-elderly who are working have employment characteristics that increase the likelihood of being without employer-based health insurance, including self-employment, low wages and salaries, and employment in smaller firms and in industries least likely to offer employer-based health coverage.

Finally, some near-elderly may be excluded from their employers' group coverage because of underwriting practices that increasingly squeeze less healthy individuals out of the market. It is unlikely that many older workers who are offered employer-based coverage opt not to receive it; overall, only about 5 percent of all workers who are offered employer-based health insurance reject it.

Additional research (Sofaer, 1990, and Davis, 1990) has shown that about 20 percent of all 50-64 year-olds, and from one-quarter to 35 percent of non-working 50-64 year olds, purchase private individual health insurance coverage (compared to about 8 percent of full-time employees ages 50-64). A greater percentage of older adults purchase individual coverage than do persons in other age groups. However, the near-elderly are particularly disadvantaged when they lose health insurance coverage and must go into the private individual market to replace it. Many uninsured near-elderly probably forego private individual coverage because of the high costs of premiums, especially for those in poorer health. Others may simply be denied coverage on the basis of a preexisting medical condition.

Approximately 17 percent of all 55-64 year-olds (almost 20 percent of those with coverage) were covered through public programs in 1987. Nearly 6 percent of the near-elderly received coverage through the Medicare program, while another 5 percent were covered by Medicaid; 8 percent were enrolled in CHAMPUS.

Characteristics of the Near-Elderly Uninsured

The characteristics of the near-elderly that lead to the greatest likelihood of being without health insurance include: low income; absence of a connection to the workforce; and minority membership (also determinants of risk for the total nonelderly population). Married near-elderly persons are also significantly more likely to have health insurance than are their unmarried counterparts. (Older women are 20 percent more likely to be uninsured than are older men). Over a third of the near-elderly with family incomes below poverty, and 22 percent of those with incomes between 100 percent and 200 percent of poverty, were uninsured in 1987. By contrast, fewer than 6 percent of those with incomes above 200 percent poverty were without health insurance protection during the same period. Nearly 16 percent of non-retired, non-working persons ages 55-64 were uninsured that year, compared to about 11 percent of full-time, full-year workers in this age group. Near-elderly Latino Whites were nearly three times as likely to be uninsured in 1986 as were non-Latino Whites in this age group. Both near-elderly Asians and non-Latino Blacks were around twice as likely as non-Latino Whites to be uninsured.

II. Health Status: Who Is At Risk?

Whatever his or her age, as an individual's health declines, he or she becomes increasingly likely to benefit from the protection afforded by health coverage against the costs of medical services. Similarly, because persons in poorer health generally are in need of more health care services than are healthier individuals, they are most likely to suffer adverse consequences from being uninsured.

Self-reported health status shows a clear decline with age. In 1989, approximately 80 percent of children younger than 18 reported that they were in very good or excellent health, compared to 73 percent of adults ages 18-44, 56 percent of 45-64 year-olds, and 40 percent of persons 65 and older. By contrast, only 2.6 percent of children under 18 were in fair or poor health, compared to 5.9 percent of 18-44 year-olds, 16.2 percent of 45-64 year-olds, and 28.5 percent of persons ages 65 and above.

Health Status of the Near-Elderly

The largest shift toward fair or poor health takes place in later middle age. Persons ages 45-64 are nearly three times as likely as their younger adult counterparts to report fair or poor health. By contrast, younger adults are 17 percent more likely to report themselves as being in good or excellent health than are the near-elderly.

Among individuals ages 50-64, reported health status is positively related to income, education, employment, non-minority membership, and, importantly, insurance coverage.[1] According to a 1989 survey conducted by Louis Harris and Associates, Inc., persons ages 50-64 with family incomes below $7500 are about two-and-one-half times as likely to report their health as fair or poor than is average for the age group. Those with family incomes between $7500 and $15,000 are almost twice as likely than is average to claim fair or poor health. (The 1987 federal poverty level for a family of two under the age of 65 was $7400.) Non-working 50-64 year-olds report fair or poor health at a rate nearly two times higher than is average for the age group, and over three times higher than the rate for full-time workers ages 50-64. Uninsured 50-64 year-olds are nearly twice as likely to report fair or poor health than is average for the age group as a whole. This trend is noteworthy; it indicates that, although a smaller proportion of the near-elderly are uninsured compared to other age groups, a significant portion of the near-elderly uninsured population (38.6 percent) are in fair or poor health. These individuals are therefore more likely to suffer the adverse consequences associated with having no insurance coverage.

III. Health Care Expenditures and Utilization of Health Care Services: Who Is At Risk?

While insurance and health status tell us much about the vulnerability of different groups within the population, it is important to supplement the information with an examination of each group's consumption of health resources. This information will help us better understand which groups are most vulnerable to large health expenditures, which groups use the most resources, and whether those groups most in need of health care services actually receive them.

The discussion below focuses on averages. However, it should be noted that, for the individual without health insurance--regardless of age--averages do not adequately convey the personal financial and emotional trauma associated with illness and injury.

Average expenditures for all health care services (the data source excludes long-term care) clearly increase with age, and are dramatically larger for older Americans. Preliminary tabulations from the NMES indicate that average per person expenditures in 1987 were $802 for children under 15 and nearly $1100 for those in the age group 35-44. But for those age 75 and older, average expenditures were more than $5400 per person. Average out-of-pocket expenditures per person for all services (the data source excludes insurance premiums) showed a similar pattern, ranging from $176 for children under age 15 and $296 for persons ages 35-44, to $1416 for persons age 75 and older (nearly quadruple the average out-of-pocket expenditures for those ages 35-44).

Except for children under the age of five, the average number of physician contacts per person in 1989 also increased with age. Perhaps due to childhood immunizations and well-baby visits, children under age five averaged more physician contacts than did any other sector of the population except the elderly. Disregarding young children, average physician contacts in 1989 increased steadily with age, from 3.5 for children over age five to nearly 10 for persons 75 or older. Older adults averaged significantly more hospital discharges (after excluding those relating to childbirth), and longer lengths of stay, than did other sectors of the nonelderly population. Beginning with the 45-64 year-old age group, these averages increased significantly with age. Due in large part to birth-related services, children under age 5 had more average hospital discharges per person, and longer average lengths of stays per person, than did all other age groups except the near-elderly and the elderly.

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[1]The exception to this last rule is that persons ages 50-64 who are covered by Medicare are by far the most likely to report fair or poor health. This fact should not be surprising, however, since most nonelderly persons with Medicare coverage have established eligibility on the basis of a demonstrably severe disability.

Health Expenditures and Utilization of Health Care Services Among the Near-Elderly

Not surprisingly, average health care expenditures and utilization of health care services generally increase with age, with the most dramatic increase, and the highest average levels of expenditures/utilization, occurring in later life. Disregarding near-elderly Medicare enrollees,[2] we find that near-elderly persons with only Medicaid coverage have the highest average expenditures, over 90 percent higher than average for the age group, followed distantly by those with private group coverage or CHAMPUS (7 percent lower than average), and by those with private, non-group insurance (14 percent lower than average). Near-elderly persons who are uninsured have the lowest average expenditures for all health care services among the coverage categories--46 percent lower than the average for the age group.

Studies indicate that the lower average health expenditures and lower levels of service utilization among the uninsured of all ages are not attributable to a need for fewer services. In fact, many of the characteristics associated with being uninsured correlate strongly with decreased health status and, therefore, with a corresponding need for more services. Rather, many individuals in the uninsured population are prevented from obtaining the health services they need because of cost. A Robert Wood Johnson survey showed that, in 1986, persons without health insurance were more than twice as likely as the total population to report not receiving care for economic reasons. This finding is consistent with more recent data, which show that, in 1984, total use of physicians' services among the uninsured was 37 percent lower, and total use of hospital inpatient services was 69 percent lower, than among the insured (Long and Rodgers, 1989).

Although the research does not distinguish by age groups, it does not seem unreasonable to assume from the data that, relative to the insured population, there may be underuse of needed health care services among uninsured individuals of all ages that results simply from their lack of insurance. Furthermore, because older persons are less likely than younger persons to be in good health, they are more likely to need more services. Therefore, underuse among older persons could be especially harmful, not only to older individuals but to society, as well. Older, sicker persons tend to be at risk for more expensive health care procedures; the longer they delay treatment, the greater the risk for more costly intervention. Those most likely to delay treatment are the uninsured and underinsured. All of us, as taxpayers and as payers of health care, finance these costs in the form of cost shifting, the provision of uncompensated care, and the extra capacity needed to maintain emergency rooms to provide primary care.

IV. Conclusion: Who Is At Risk?

An examination of the interaction among the three risk factors we have been discussing--health insurance status, health status, and health care consumption--sheds light on the vulnerability of different age groups. The near-elderly, who are least likely among the nonelderly to be without health insurance, are also in the poorest health, have the highest average total and out-of-pocket expenditures for all health care services, and, with one important exception, have the highest rates of utilization of health care services. The exception is for young children, who, primarily because of the need for services related to birth and well-baby care, average more physician contacts per year than do persons in any other age group except the elderly, and more hospital discharges than all but the near-elderly and the elderly. Young adults, who have the greatest likelihood of being without health insurance, are in significantly better health than are older persons, utilize correspondingly fewer health care services (with the exception of hospital services related to childbirth), and have lower average health care expenditures. Nevertheless, it should be noted that lack of health insurance among one particular group of young adults--pregnant women--often serves as a barrier to receiving needed prenatal care, representing a significant risk to these women and their children, as well as to society as a whole.

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[2]Near-elderly Medicare enrollees have unusually high health service utilization because most have established Medicare eligibility on the basis of a demonstrably severe disability.

Therefore, although fewer of the near-elderly are without health insurance, those who are uninsured are at a higher risk of suffering adverse consequences as a result. This risk is even greater given that many of the characteristics of the near-elderly that lead to an increased likelihood of being uninsured--for example low income, absence of a connection to the workforce, and minority status--also relate to poorer health and to the need for more health care and more services.

C. TARGETED STRATEGIES TO EXTEND HEALTH INSURANCE COVERAGE TO THE NEAR-ELDERLY

I. Traditional Proposals

A number of targeted solutions, both private and public, have been proposed for providing coverage to the uninsured, some of which would clearly benefit individuals between the ages of 50 and 64. Targeted private sector solutions include: expanding COBRA Group Health Insurance continuation coverage; requiring employers to provide insurance coverage to their workers; using tax credits to further reduce the cost of employer-provided coverage; and creating risk pools for individuals with large medical expenses.

None of these targeted solutions is without shortcomings or drawbacks. For example, COBRA continuation coverage is limited to no more than 36 months; further, such group health insurance is likely to be prohibitively expensive for many, since the qualifying enrollee must pay both the employer's and the enrollee's share of the group premium. Employer mandates may threaten the stability of small firms, and/or result in wage or hiring reductions, especially in firms with workers concentrated at or near the minimum wage level. Tax credits for small employers may increase inequities between small and larger businesses, and more importantly, such employer incentives do not address the problem of the nonworking uninsured. Finally, risk pools have proven to be a relatively ineffective means of covering the uninsured, primarily because, without public subsidies, pool premiums tend to be very high, and, therefore, broadening of the enrollee base difficult.

Proponents of targeted public sector solutions would typically extend coverage to the uninsured through the Medicaid program, either by expanding Medicaid eligibility or by allowing certain groups to "buy into" the Medicaid program. But the Medicaid program is plagued with problems, including escalating program costs, inadequate provider reimbursement levels that limit access, and chronic susceptibility to budget cuts.

II. An Alternative Approach: Medicare Expansion

Another targeted approach, one that could be used to expand health insurance to some of the most vulnerable persons among the uninsured population, involves expansion of the Medicare program to cover various sectors of the near-elderly population.

The approach currently being considered by this Committee is composed of three parts: (1) automatic Medicare entitlement for disabled individuals ages 62 or older through elimination of the current two-year waiting period for non-elderly disabled persons; (2) a buy-in option for Social Security Old-Age and Survivors beneficiaries 62 years of age or older; and (3) buy-in options for spouses, ages 62 or older, and children, under age 18, of Medicare beneficiaries. The buy-ins would be partially financed by premium contributions from new enrollees.

How does the proposed Medicare expansion compare to some of the other targeted approaches that have been offered? Expanding Medicare is an attractive option for several reasons. This approach would build on an existing program that is both familiar to and well understood by most people. Moreover, Medicare is a program that is extremely popular with individuals of all ages. Unlike some of the other targeted approaches, an expansion of Medicare would rely on a program that has been highly successful in keeping administrative costs to a minimum; currently, Medicare's administrative costs, around 2 to 4 percent of total program costs, are a fraction of those associated with employer-based health insurance. Finally, although gaps in Medicare's coverage are significant--including absence of coverage for prescription drugs, dental, vision, and respite care, as well as inadequate home health benefits--Medicare nevertheless offers a relatively complete benefit package. Whereas other targeted approaches would guarantee neither adequate nor uniform benefits across all persons newly covered, this approach would assure that everyone is covered for a minimum package of comprehensive benefits.

Notwithstanding its strong points, the proposal raises a number of important questions and concerns. For instance, and perhaps more importantly, if we are to adopt an incremental approach to comprehensive health care reform, how do we select those groups who will benefit first from targeted improvements? Also, would this proposal contribute to an effective incremental approach that would help to move the country closer to comprehensive reform of the health care system?

More specific to the option proposed, how would we determine the proper contributions that newly enrolled individuals would make to buy into Medicare in order to maintain the program's social insurance nature? Should they enjoy the same level of subsidization from which all current Medicare beneficiaries now benefit? Should individuals who never paid into the program through FICA or had matching contributions from an employer be offered the same level of subsidization as other new enrollees or current beneficiaries?

How would the proposal treat individuals who are currently covered under an employer-based health plan? Would the proposal prohibit or otherwise limit such an individual's ability to buy into Medicare, even if his or her contributions toward employer-based coverage exceeded the cost of the buy-in? And, last but not least, how would the additional costs be financed?

D. COSTS AND IMPACTS OF EXPANDING MEDICARE TO 50-64 YEAR-OLDS

I. Covering Persons Age 50 to 64 Under Medicare: Costs and Impacts

At the request of AARP, Lewin/ICF has estimated the cost and impacts of extending Medicare coverage via a heavily subsidized "buy-in" to all individuals between the ages of 50 and 64 (including those with existing public or private coverage). The Lewin/ICF estimates produce an outer boundary of potential costs for the inclusion of this age group in the Medicare program; the estimates reflect the assumption that all individuals in this age range would automatically be eligible, that all newly eligible individuals would receive full Medicare benefits, and that Medicare would be the primary payer for workers and dependents. They further assume that newly eligible individuals would pay only the Part B premium (or $29.90 per month in 1991).

Under such a scenario, Medicare program enrollment would rise by 34 million persons, and total program costs would rise by $47 billion, or an average of $1,374 per new enrollee. (See Table I). Income from premiums ($29.90 per month in 1991) would reduce net new Medicare spending to $36 billion. Adjusting for savings in all other categories of federal health spending and for increased corporate income tax payments, net new federal spending would total $28.8 billion. (See Table II).

The net change in health spending overall in the economy would be small--$0.8 billion--reflecting savings to employers, state and local governments, families, and hospitals (for uncompensated care). (See Table III). Private employers currently providing health insurance would see their health expenditures reduced by 12.9 percent. Firms employing 10-24 employees would experience the most significant reduction (16.4 percent). (See Table IV).

Spending on health care by families with one or more members ages 50-64 would be reduced by $3.4 billion. Average out-of-pocket expenses would fall for virtually all affected families. A family with annual average out-of-pocket spending in excess of $10,000 would see its out-of-pocket costs drop on average by 50 percent, and all families would see the share of income they spend on health care reduced by an average of 15.5 percent. Moreover, the out-of-pocket savings would be most dramatic in families with incomes below the federal poverty line. These families would see their out-of-pocket spending on health care reduced, on average, by one-quarter. (See Tables V).

The Association would be happy to provide similar estimates for the 62-64 year-old population, as well.

E. CONCLUSION

The uninsured population is a heterogeneous one, comprising the young, the middle-aged, the old; all ethnic groups; low, middle, and high-income groups; workers and nonworkers; those living alone and those living in families; the educated and the uneducated. The uninsured also differ along the dimension of persistency of coverage; some are without coverage periodically, while others are chronically uninsured. Nevertheless, the interactive effects of lack of insurance, poor health status, and high consumption of health care services help us to identify several groups with disproportionate vulnerability: the poor/near-poor, regardless of age; minorities, especially Blacks and Hispanics; children, young adults, and the near-elderly.

The size and diversity of the uninsured population in this country, and the fact that significant portions of all age groups (except the elderly) are without health insurance argue strongly for a comprehensive approach to reforming the health care system. AARP has long supported such an approach to providing affordable, needed care to everyone. Assuring that persons of all ages have access to health care coverage and services is an integral component in ensuring value for our health care expenditures.

Public surveys indicate that Americans view health care as a right, and that the public overwhelmingly supports extending coverage to all uninsured people. AARP recognizes that progress may be achieved in incremental steps, but we believe that each of these steps should move the country closer to the goal of comprehensive, affordable acute and long-term care for people of all ages. Making the necessary changes in our health care system to provide acute, preventive, and long-term care services to all Americans, while restraining costs and improving the quality of care, is perhaps the greatest challenge for our nation in the 1990s.

The Association commends you, Chairman Stark, for your efforts to examine ways to extend health insurance to vulnerable sectors of the near-elderly population. AARP stands ready to work with you and your colleagues as you explore options to begin moving the nation toward comprehensive reform of the health care system.

TABLE I

COVER PERSONS AGE 50-64 UNDER MEDICARE

PROGRAM ENROLLMENT AND COSTS BY AGE GROUP IN 1991

	Persons Newly Covered Under Medicare[a] (In Millions)	Program Cost[b] (In Billions)	Cost Per Enrollee
Age of Individual			
50-54	14.9	$15.9	$1,067
55-59	11.5	15.7	1,365
60-64	7.8	15.4	1,974
Total	**34.2**	**$47.0**	**$1,374**

a Excludes disabled persons age 50-64 already covered under Medicare.

b Includes benefits and administrative costs. Assumes Medicare reimbursement principle.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

TABLE II

COVER PERSONS AGE 50-64 UNDER MEDICARE

CHANGE IN FEDERAL HEALTH EXPENDITURES
IN 1991
(In Billions)

Medicare Expenditures		
HI Program Benefits[a]	*$22.3*	
SMI Program Benefits[a]	*23.5*	
Administrative Costs[b]	*1.2*	
Less Part B Premium Payments for Newly Eligible[c]	*(10.9)*	
A. Net New Medicare Spending		*$36.1*
Offsets to Other Programs[d]		
Reduction in Federal Medicaid Spending	*1.2*	
Reduction in CHAMPUS Beneficiaries	*1.7*	
Reduction in Federal Civil Service Employees	*0.4*	
Increased Corporate Income Tax Payments[e]	*4.0*	
B. Total Program Offsets		*7.3*
Net New Federal Spending (A-B)		*$28.8*

Lewin ICF

TABLE III

COVER PERSONS AGE 50-64 UNDER MEDICARE

CHANGE IN HEALTH SPENDING FOR PERSONS AGE 50-64 IN 1991
(In Billions)

Household Expenditures		*(3.4)*
Premium Payments	*3.1*	
Direct Payments for Care	*(6.5)*	
Federal Health Spending		*28.8*
Private Employer Health Spending		*(12.7)*
Hospital Uncompensated Care		*(2.3)*
State and Local Government Spending		*(9.6)*
Net Change in Health Spending		*0.8*
Utilization Increase[a]	*2.1*	
Administrative Savings[b]	*(1.3)*	

a *Utilization is assumed to increase for newly insured persons to a level comparable to those who are currently insured.*

b *Many individuals are shifted from employer plans to Medicare where administrative costs are lower.*

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

TABLE IV

COVER PERSONS AGE 50-64 UNDER MEDICARE

CHANGE IN PRIVATE EMPLOYER COSTS FOR WORKERS AND DEPENDENTS BY FIRM SIZE IN 1991

	Employer Costs Under Current Law[a] (In Billions)	*Change in Costs Before Taxes (In Billions)*	*Percent Change In Employer Costs*
Size of Firm			
1-9	*8.0*	*(1.0)*	*(12.5%)*
10-24	*13.4*	*(2.2)*	*(16.4)*
25-99	*15.9*	*(2.5)*	*(15.7)*
100-499	*23.6*	*(3.7)*	*(15.7)*
500+	*52.6*	*(5.3)*	*(10.1)*
All Private Employers	*113.5*	*(14.7)*	*(12.9%)*

a *Includes the employer share of costs for employees and dependents. Excludes costs for retirees.*

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

TABLE V

COVER PERSONS AGE 50-64 UNDER MEDICARE

CHANGE IN AVERAGE FAMILY OUT-OF-POCKET EXPENSES FOR AFFECTED FAMILIES BY INCOME IN 1991[ab]

Income As A Percent of Poverty	Average Out-of-Pocket Spending Under Current Law	Change in Out-of-Pocket Spending	Percent Change In Out-of-Pocket Spending
Below Poverty	$1,322	$(336)	-25.4%
100%-149%	1,974	(310)	-15.7
150%-199%	2,296	(400)	-17.4
200%-299%	2,251	(289)	-12.8
300% or More	2,367	(335)	-14.2
Family Income			
Less Than $10,000	$1,290	$ (227)	-21.5%
$10,000-14,999	1,813	(248)	-13.7
$15,000-19,999	2,072	(305)	-14.7
$20,000-29,999	1,936	(255)	-13.2
$30,000-39,999	2,455	(375)	-15.3
$40,000-49,999	2,243	(314)	-14.0
$50,000 or More	2,740	(426)	-15.6
All Families	$2,135	(331)	-15.5%

a Includes families with one or more member age 50-64.
b Out-of-pocket includes changes in premium payments and direct payments for health services.

SOURCE: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Preamble

AARP believes that the United States has the resources to ensure access to acute and long term care for all individuals, and to control health care costs without compromising quality of care. Efforts to reform the health care system must recognize the need to provide acute and long term care over the course of an individual's lifetime. AARP recognizes that advancement may be achieved in incremental steps, but we believe that each of these steps should move the country closer to the goal of comprehensive, affordable acute and long term care for people of all ages.

The following sets of principles are designed to guide the Association in its efforts to reform our current acute and long term care systems. The principles do not address every specific issues relating to health care reform, but they do establish criteria for evaluating and comparing reform proposals. They also serve to guide the Association in its participation in the public debate over health care reform.

Long Term Care Principles:

1. Long-term care services should be **available to all** people who need them, regardless of age or income. The long-term care program should base eligibility for services on a person's physical and cognitive functioning, including limitations in performing activities of daily living (e.g., eating, bathing and dressing) and a person's need for supervision. Uniform, national assessments should determine whether a person meets the eligibility criteria for the program and the type and level of care that a person needs.

2. A national long-term care program should provide a comprehensive **range of services.** These services should include: (1) in-home assistance; (2) community services; (3) long-term care services in a full range of supportive housing options (4) institutional care; and (5) rehabilitative services. Long-term care should be provided in the least restrictive setting possible.

3. The new public program should assist, not replace, current informal **caregivers.** Families and friends need access to supportive services so that they are not unreasonably burdened and can continue to provide care. The services should include respite care, adult day care, and other types of assistance, such as an expanded dependent care tax credit.

4. Implementation of the public program must be **phased-in** to ensure orderly development of the new system. Expansion of services should be accompanied by development of a long-term care infrastructure, including health care personnel, that will permit the delivery of a comprehensive range of home, community and institutional services.

5. The principles of **social insurance** (e.g., Social Security or Medicare), and shared risk must be extended to long-term care. Under social insurance programs, individuals pay into the system and are then entitled to benefits when they are needed. By spreading the cost across the entire population, universal protection can be achieved in an affordable, equitable manner for everyone.

6. The new long-term care program should be **financed** primarily through taxes earmarked to a trust fund. Revenue sources could include payroll taxes, increased estate and gift taxes, income taxes and modest premiums. The new public program must be financed through taxes and premiums so that it does not increase the federal deficit.

7. The new public program must provide a solid **foundation for protection,** upon which the private sector can build. The private sector could supplement the public program by covering the program's copayments and deductibles, as well as services that the public program does not provide. Any private sector approach (e.g. long term care insurance) should be subject to strong standards to protect consumers from inadequate products.

8. **Payment to providers** of long-term care services must be reasonable and provide financial returns to providers who deliver quality care. Reimbursement systems for home, community, and institutional care must respond to clients' needs, promote delivery of quality care, and recognize the outcomes of care provided to clients.

9. **Cost containment** mechanisms must be built into the new long-term care system. Use of services could be controlled by providing a defined set of services to beneficiaries. Modest deductibles and copayments also should be included. However, people with low incomes should be protected.

10. The federal and state governments should assure delivery of **quality care** under the new long-term care program. Recent improvements in the quality assurance systems for nursing homes and home health agencies should be swiftly and vigorously enforced. In addition, new methods of assuring the quality of other home and community services must be found.

Preamble

AARP believes that the United States has the resources to ensure access to acute and long-term care for all individuals, and to control health care costs without compromising quality of care. Efforts to reform the health care system must recognize the need to provide acute and long-term care over the course of an individual's lifetime. AARP recognizes that advancement may be achieved in incremental steps, but we believe that each of these steps should move the country closer to the goal of comprhensive, affordable acute and long-term care for people of all ages.

The following sets of principles are designed to guide the Association in its efforts to reform our current acute and long-term care systems. The principles do not address every specific issue relating to health care reform, but they do establish criteria for evaluating and comparing reform proposals. They also serve to guide the Association in its participation in the public debate over health care reform.

Acute Care Principles:

1. All individuals have a right to receive health care services when they need them.

   The public, through the federal and state governments, has the ultimate responsibility to develop a system that ensures reasonable and equitable access to needed health care services for all individuals.

2. All individuals have a right to reasonable access to health care coverage that provides adequate financial protection against health care costs.

   The public, through the federal and state governments, has the ultimate responsibility to develop a system that ensures universal access to health care coverage for all individuals, including individuals with disabilities or health problems. The health care system should be designed to ensure that all individuals are covered by a public or private health coverage plan. The government should establish a minimum benefit package to which all individuals are entitled.

3. All individuals have a right to high quality health care.

   The health care system should collect, analyze, and disseminate information about provider performance, health care outcomes, and the appropriateness and effectiveness of health care services. Quality assurance programs, such as peer review and professional licensure, should be strengthened and coordinated.

4. All individuals should have a reasonable choice of health care providers.

   Cost containment efforts should not unreasonably limit choice of providers. Consumers should be provided with sufficient information about health care providers and treatment options to make informed health care decisions.

5. Financing of the health care system should be equitable, broadly based, and affordable to all individuals.

   Government, employers, and individuals share the responsibility to participate in health care financing.

Our present method of financing health care should be replaced by fairer, more progressive financing approaches. Burdensome cost-sharing requirements (e.g., burdensome deductibles and coinsurance) should be avoided because they disproportionately affect the sick and the poor. The public, through the federal and state governments, should subsidize the cost of health care coverage for individuals with lower incomes and should fully finance health care coverage for the poor. Any financing method should preserve the dignity of the individual, regardless of his or her income level.

6. Methods of provider reimbursement should promote cost containment, encourage efficient service delivery, and compensate providers fairly.

   Health care providers should receive basically the same reimbursement for the same services within a given area, regardless of the payment source. The government should play a major role in establishing more uniform reimbursement practices and rates for health care providers. Health care providers share in the responsibility to be fiscally prudent.

7. Health care spending should be more rational and should be managed through more effective planning, budgeting, and resource coordination.

   The distribution and allocation of health care resources (e.g., capital, technology, and personnel) should encourage innovation, efficiency, and cost effectiveness, and should promote reasonable access to services. Federal and state governments should play a major role in planning and coordinating the allocation of health care resources.

8. Health promotion and disease prevention efforts should be strengthened.

   The public health system (e.g., water and sewer service, environmental protection, occupational safety, etc.) should be strengthened to ensure the public's health, safety, and well-being. Public health efforts should: (1) increase citizen understanding and awareness of health, environmental and safety issues and problems; (2) improve access to primary and preventive care services, such as maternal and child health care, immunizations, and nutrition counseling; (3) conduct health, environmental, and safety-related research; (4) coordinate the collection and dissemination of information about health, environmental, and safety issues; and (5) assure compliance with health, environmental, and safety standards.

9. Individuals share a responsibility for safeguarding their health by educating themselves and taking appropriate preventive measures to protect their health, safety, and well-being.

   The government, health care providers, and consumer organizations share in the responsibility to educate the public about health care. Differentials in contributions for health care coverage to encourage healthy behavior can be appropriate as long as they do not deny access to health care.

10. The acute and long-term care systems should be coordinated to ensure a continuum of care across an individual's lifetime.

AMERICA'S NEAR ELDERLY: CASE STUDIES OF INDIVIDUALS WITHOUT INSURANCE

Compiled by AARP
Department of Federal Affairs
March 19, 1991

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Robert B. Maxwell *President* Horace B. Deets *Executive Director*

NEAR ELDERLY WITHOUT INSURANCE
Case Studies

Thirty-four million Americans have no health insurance. A large segment of this uninsured population are the near-elderly---those between the ages of 50 and 64 who are not yet eligible for Medicare and yet may be unable to obtain private coverage because of a pre-existing condition or prohibitive premiums.

AARP receives hundreds of letters from its members who are in this category. We have selected representative member letters and have categorized them into three groups: (1) the early retiree; (2) the individual who is forced into retirement on disability and must wait 24 months for Medicare coverage; and (3) the younger spouse of a retiree who loses health-care coverage due to his/her spouse's retirement.

We will introduce each group with a brief description of their common problem and then let the letters speak for themselves. For further information pertaining to these cases, please contact the AARP Federal Affairs Department at (202) 728-4788.

Early Retirees

When an individual retires at age 62, he/she is eligible under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, Public Law 99-272) to continue the employer's group health coverage plan for 18 months. However, when COBRA protection expires, the retiree still has up to 18 months before becoming eligible for Medicare. If the early retirees are fortunate enough to have an insurance company which will allow them to continue with an individual plan, many find the monthly premiums prohibitive. Many complain of premiums which escalate each month to the point where they are forced out of the plan. Still others, due to pre-existing conditions, find the plans offered have exclusionary riders or, in many cases, find they are refused coverage.

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May 1990

My husband retired in January 1989 at age 62. Now he is 63. His insurance will increase from $450 to $776.70 (per quarter) beginning June 1, 1990. He has worked with the Painters Union for over 35 years. He took early retirement at 62 because of health reasons. But we didn't know the insurance would be this high. So, he has one year and nine months left before Medicare.

Are many people faced with this increase in insurance, and what can we do about it? I work part-time at the Red Cross.

Fridley, Minnesota

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June 26, 1990

Generally, health care services seem to be adequate for most of our people, but health insurance coverage to pay for the service is the problem. The problem, in short, is the availability and affordability of the health insurance.

The comments that follow must be the thoughts of millions of people like myself who have elected to retire "early" at age 62. Actually, as you must know, age 62 is no longer early retirement for most people. Most people I know, no longer work to "normal" retirement age 65. Because of the changing workplace, most people elect to draw Social Security benefits at age 62 because their employers have eliminated their jobs or have changed the conditions of their jobs which makes it impossible for them to carry on. Therefore, age 62 can now be considered normal retirement age.

Obviously, at age 62 and beyond, we are all very concerned about maintaining our health insurance. Prior to my decision to retire, I checked with my employer about this subject. In particular, I inquired about the possibility of continuing the company sponsored health insurance to age 65 in order to dovetail with Medicare available at that time.

My employer told me this subject is universally asked by all people retiring at age 62. Furthermore, they told me they would be more than willing to continue my coverage to age 65 (at my expense by reimbursement to the employer) but that when this possibility was suggested to their insurance carriers, the insurance carriers declined to agree and that coverage could only be continued for the mandated 18 months provided under COBRA. I don't think I need to list the problems associated with a search for health coverage at age 63 1/2.

Maybe this suggestion is too simple, but take it for what it's worth. Use AARP's muscle to lobby for a change in COBRA's mandated 18 months, extending it to 36 months. A simple solution to the problem of availability and affordability for millions of people retiring at age 62. Do you agree?

Minnesota

****

June 1990

My husband, 63, was recently forced into an early retirement because of financial problems within the company, and we were forced to pick up company insurance at 102% of the cost, which represents $273.40 per month, plus an additional $400 family deductible. After the deductible is met, we are responsible for 20% of medical expenses incurred. According to COBRA, we are eligible for 18 months beyond his termination of duties from the company, which leaves us at ages 59 and 64, too early for Medicare for either of us. I have inquired of numerous companies, and the same response is given with each call. They will <u>not</u> insure privately unless your previous employer carried that particular company. To compound the problem, my husband was employed by a self-insured company, leaving us in worse straits.

In addition, many or most companies, when enrolling new people, will refuse you coverage if you have preexisting medical problems. Also, the costs are horrendous, with all kinds of riders and exclusions.

Medical costs are soaring...one oral surgeon's receptionist told me very emphatically over the phone that I would be expected to "pay for services" that day ...$100 for an x-ray and a check of a node in the neck. Our insurance company would not cover 80% because they claimed the cost "exceeded the reasonable and customary amount."

I thoroughly believe there must be something done in the state to ensure people of all ages access to adequate medical care. Why can't there be a carrier statewide? I am <u>not</u> proposing free insurance, but decent coverage with a fair monthly premium.

Lastly, with all due respect, if the legislators on both state and federal levels found themselves in the positions of millions of Americans today, I feel sure legislation would be promptly enacted!

Feeding Hills, MA

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August, 1989

There is a very urgent problem in this country that needs the attention of every congressman and senator of the U.S. Please allow me to bring some facts to your attention of how John and Jane Does by the thousands are falling through the cracks on insurance coverage.

In January of last year, I retired from the work force at the age of 63. I had been covered by Blue Cross insurance for over twenty years and retired fully believing I was covered by the COBRA law which would allow me to continue my insurance at the group rate of $80.40 per month until I went on Medicare and then would carry the supplement on the policy.

This was a pipe dream and turns out to be a nightmare. I find I am not covered by COBRA because the company I worked for did not have 15 or 20 employees required to conform to the law. I wonder if you realize how many small company employees are caught in this same bind and just how discriminating this law really is to millions of workers out in the work force. To be able to continue under the policy does not cost the

employer one thin dime as the employee picks up the bill in full and in advance of the payment due date. Why just pass a bill that protects people who work for big plants and discriminate against people who work for small companies? Not only does it discriminate, but it causes real hardships and in some cases people to be without insurance because of the high cost.

Let me cite the facts in my case: with the group plan, I was paying $80.40 per month with a $100 deductible. When I was forced to go off the group plan and go private in order to continue the coverage, they ridered the policy because I had a cholesterol problem, which I had for over a year while paying $80.40. Instead of $100 deductible, it was raised to $1,000 and the premium was raised to $256.63 per month. In May, I was billed at $325.92 per month; and in June $487.60 per month. This only covers one person.

My Social Security check is less than $400 per month so my only choice was to drop the policy. At 63, new policies have 6- or 12-month waiting periods for pre-existing conditions, but that is my only choice. As you can see, there is a segment out here that is being completely overlooked in coverage when we leave the work force from small companies. I urge you to give this your full attention as soon as possible.

North Carolina

****

1989

I recently applied for Blue Shield medical coverage to cover me until I reach 65 and receive Medicare. I am currently 61 years of age. They took the material forwarded at their request from my internist, and because of minor conditions I consulted him for in the past five years (they regarded it as a major debilitating illness), they denied me coverage. I am currently completely healthy. I believe the problem is my age only. As it is, my Blue Shield would cost me $170 or more covering a $500 deductible policy. I have not collected from any insurance company in the past decade even $500 for health coverage -- yet they are denying me coverage.

San Jose, California

****

1989

My husband and I are each 58 years of age and not yet eligible for Medicare. We find that I am not eligible for most health coverage. I was diagnosed as having "moderate pulmonary emphysema" in February of 1975. I also have had fibroid breast for many years. Last year's mammogram had a change so small that my doctor didn't even bother to mention it to me. Of course, we both hesitate to go to the doctor now. If a doctor is careful enough to take tests, even negative results count against you with the insurance companies. If I had another mammogram and it showed a problem, we could not afford to do anything about it anyway. There are so many like us and the insurance companies are not going to change unless forced to. People over 65 have Medicare and still have problems, but those under 65 with pre-existing problems are really left out in the cold.

California

1989

My husband looked forward to retiring at age 62. We felt fortunate that we were allowed to convert the medical insurance the company had carried on us and pay $181 per month for coverage for both of us. Four months later the cost rose to $248 per month, and though it did put a strain on our budget, we continued to carry the insurance. In July of this year, the HMO we had was taken over by another HMO and on August 1st, our coverage was raised over 60% to $412.50 per month. We paid for August and then had to face the reality that we could not continue the coverage on our small income.

Tucson, Arizona

****

May 1989

I retired at 62 and am presently drawing $514.00 per month Social Security. When I left my company at age 62, they had no retirement program and I lost my major medical insurance when I retired. My problem is that I have heart trouble, and am a diabetic and no insurance company will write me a policy mainly because of my heart trouble. It will be one year before I am 65 and can go under Medicare, and I live in constant fear of having to go to the hospital (without insurance). I have applied for food stamps, welfare and any help I can get from all agencies and have been turned down. I served my country in the army (Korean war) and I feel like I deserve better treatment than I am getting from all of these agencies!

Anderson, South Carolina

Younger Spouses of Retirees

Spouses of retirees who are covered under their husband/wife's employer insurance are eligible to continue this coverage for 36 months under COBRA. However, after COBRA expires, they are in the position of having to find individual coverage at an advanced age and in a high-risk category. They then face the same problems as the early retiree--high premiums, riders which exclude pre-existing conditions, or refusal of coverage. One woman noted that in her futile search for coverage, she was consistently asked on application forms if she had previously been denied insurance by another company. "Will any company accept you after you've admitted that another company has turned you down?" she asked.

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January 1990

I am soon to become another one of the unfortunate "uninsurable" victims. I was covered under my husband's employer medical insurance program (inasmuch as I worked only part-time and none was available to me). He lost his battle with cancer in 1987 - an acknowledged victim of Agent Orange - a result of 25 years of dedicated military service.

Per Federal Regulations, his employer offered me "COBRA" coverage for 3 years.

Six months after his death, I was diagnosed with colon cancer and seven months after that it was breast cancer - non-related.

I will lose the COBRA benefits before long and have been searching for coverage. The outlook is very sad - very pathetic. No one will cover me, or even discuss coverage with me, even though I have been considered free from the colon cancer for almost two years and free from the breast cancer for over a year. I have a window of a 7-year period before I qualify for Medicare.

The auto insurance companies are forced to take a certain percentage of high-risk drivers. These are people who have created their own problems - YET they are protected - the insurance companies must make coverage available to them.

Why then, cannot health insurance companies be forced into accepting a certain number of high-risk people, like myself. We aren't even guilty of creating our own problems - just victims of chance - be it cancer, heart attacks, or whatever has plagued us.

I sincerely feel this country needs some type of National Health Insurance. It has been proven it works in every other country in the world, whether it is called Socialized Medicine, National Health or whatever - it works. What is ludicrous is the fact that these programs are being supported by our billions of dollars that are poured into these countries as foreign aid.

It would be very refreshing and most appreciated by all of us in this situation if our country put some of this money into aid for us - the people of this country - we need help too!

California

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1989

My husband turned 65 last year, so after 43 years of hard work decided to retire. Unfortunately, just months before his retirement, I found I had a 99% blockage in my carotid artery -- had surgery immediately. Paid insurance all our life, but his company refused to cover us after his retirement. Blue Cross/Blue Shield took us with a 5-year rider on my pre-existing condition. Our insurance costs us a total of $855.78 every 3 months, but does not cover me for heart, arteries, or lots of things.

Michigan

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March, 1991

I need some information on who I can contact on any kind of health and medical assistance here is the State of Kansas. My wife cannot get health insurance--at least she was turned down by two companies. She is 57 years old, and I just brought her home from the hospital last Saturday, February 23, after surgery and being in the hospital six days. Of course, before surgery, there were many tests run, many doctor's office appointments along with three months of this. I am retired, 66, and we both belong to AARP.

This country needs a National Health Care Program badly, and I know AARP is behind this. This isn't going to help me as of now. Of course we now owe thousands of dollars and we tell them all they can only expect so much payment every month. Since I am on Social Security and my wife was working part-time--but has not worked in 30 days and will not work for maybe two or three more weeks. She works for the Board of Education here in Wichita. But as I said, only part-time with no benefits. And of course, school will be out June, July and August and she cannot work.

I know you probably get this kind of letter all the time. Maybe you can tell me who to contact - if anyone. Our bills are spiraling upward.

Wichita, Kansas

Disabled Beneficiaries

An individual who becomes disabled and qualifies for Social Security disability must wait 24 months before receiving Medicare benefits. The present COBRA law provides that these persons may continue their insurance coverage under their former employer's group plan for 29 months. Despite this law, people are finding that there are gaps and they are falling through the cracks. For example, there may be delays in obtaining the Social Security determination, which can result in COBRA running out before the person becomes Medicare eligible. People who have worked for companies with less than 20 employees are not covered by COBRA. Also, the under-65 disabled who qualify for Medicare cannot purchase Medigap policies.

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March 11, 1990

On August 8, 1989, I became totally disabled and had to give up a lucrative career. I am now receiving Social Security under disability. I am 59 years old.

My problem is that I am not eligible for Medicare at present. There is a 24-month waiting period before I may enter the system.

This ruling seems to be punitive on the disabled. If I were to try to purchase an individual policy with my present disability, either I would be rejected or the premium would be out of my reach. Is there any advocate that I may write to regarding this situation?

I've had health insurance all of my working years and other than two pregnancies, have never had to avail of these services. Now that I need health insurance, it is out of my reach.

Sacramento, California

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February 1990

We write to you to suggest that a certain portion of the population is being woefully ignored -- the over 62 population that must apply for Social Security benefits due to medical reasons, and yet cannot obtain Medicare because it is not granted until the age of 65.

I am such a person. I will be 62 in May. I must apply for Social Security benefits. Until now, I have been working quite a number of hours at home, doing home typing. However, I must cut down my hours because of heart disease (I have already had two open heart surgeries with not much success), pernicious anemia (which flares up occasionally), acute glaucoma and hypothyroidism, which are controlled with medication.

My problem is that I carry Blue Cross/Blue Shield privately for medical insurance and this is very expensive. Cutting down on my hours will cause a severe hardship on my husband and myself since he is already on disability and has been so for several years because of rheumatoid arthritis. My income has always been necessary to supplement his Social Security benefits. Needless to say, I must continue with medical insurance, but cutting down my working hours because of health reasons will cause a hardship so severe that supplementing my husband's benefits for normal everyday living expenses might have to be sacrificed in order to pay for my private medical insurance. And yet, if I do this, how can we buy the necessities of life? On the other hand, if we do not cut the living expense, how can we pay for my private medical insurance? As for Medicaid,

we will not be eligible because between my husband's Social Security, the Social Security I will receive and the small, very small supplemental income I will earn as a home typist, we will be earning what is considered as too much for Medicaid.

Medicare for people like myself would be the answer. My husband and I have already written to several Senators, including the Committee on Aging in the Senate, to ask that Medicare be granted to over-62 people with medical conditions. I could apply for disability, but then I would be unable to work if I am granted it, and even if I have Medicare with disability, where is that extra income for living expenses?

Brooklyn, New York

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April 1989

*I just retired on disability from my job because of blindness at the age of 59. For some time I can retain my health insurance coverage for myself and my wife through individual contributions to the program amounting to $279 per month. That I will do. However, in eighteen months that possibility ends. ** This will leave me and my wife uncovered for two or three months until we are eligible for Medicare. That worries us. More important in the long run, we cannot obtain a Medicare supplement policy. AARP does not offer any for people in our age category who are retired on disability. Neither does anyone else.*

I believe that every major consumer group in America has disregarded the health insurance needs of younger people who have worked and been forced to retire on disability. Waiting for Medicare for 29 months after filing for disability is outrageous. In addition, not being able to get Medicare supplementary insurance after finally qualifying for Medicare is a further outrage.

Fresno, California

*** Note: Current law allows 29 months of COBRA coverage for the disabled.*

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September 1989

As Medicare is becoming such a "hot" topic for seniors and members of elected parties, perhaps the so-called inequities in American health care should also be addressed at this time.

In essence, what are citizens who have worked ALL their adult life supposed to do for their medical needs when having to retire between the ages of 62-65 because of poor health? When unable to work, many lose their health insurance through their work...but are offered a COBRA insurance for 18 months at a horrendous cost of approximately $4,000 annually for husband and wife. (Illinois offers CHIPS insurance which costs even more). Most of these retired workers in poor health cannot afford these high insurance premiums and then there is the high cost of their required medicines to add to their medical expenses. What does one do in the interim with no insurance until 65 and Medicare?

Unless the retiree is almost destitute he/she cannot obtain "relief" through the state or federal government. A worker who has saved "for a rainy day" therefore is forced to spend all his/her savings to keep up with medical needs...food or medicine?---Like WWII "guns or butter" was the slogan in Europe.

Eventually, the savings run out and his/her age has not reached 65 and Medicare. As the seniors' savings are spent on medical needs, it becomes harder for them to pay for

basic necessities such as rental or house taxes. Food and shelter of all kinds becomes difficult to buy, especially if they are on special diets for their medical condition.

In turn their life becomes intolerable and we will see more seniors becoming depressed and fed up with just existing under these circumstances. If only the government would provide (in some way) for health care for those disabled/retired ex-workers between the ages of 62-65...so that their senior years might become more tolerable when faced with projected enormous medical bills at this age.

After all, these seniors 62-65 did not ask to be ill/uninsurable...it became something that they did not expect. Surely after working an average of 40-45 years and paying in much money to Social Security, they should be able to get help with all their medical needs including prescription drugs.

Countries where there is socialized medicine or some kind of similar plans are fortunate and citizens of such plans all agree that apart from flaws in this kind of system, when they become retirees knowing that their medical needs will be taken care of gives them peace of mind and happiness in their golden years compared to despair and agony associated with the U.S.'s unfair medical system for the elderly.

Illinois

BA3-STA-311

Mr. COYNE [presiding]. Mr. Flemming.

STATEMENT OF HON. ARTHUR S. FLEMMING, CHAIR, SAVE OUR SECURITY COALITION, AND FORMER SECRETARY OF HEALTH, EDUCATION, AND WELFARE

Mr. FLEMMING. Thank you very much. I appreciate the opportunity of participating in this hearing on the Medicare Eligibility Expansion Act of 1991.

I concur in the statement issued by the chairman, when he announced the introduction of this particular bill, to the effect that "the absence of universal national health insurance is a national disgrace."

Furthermore, I believe that we should address this particular issue with a sense of urgency. It is unconscionable for us to watch millions of our people experience unnecessary suffering and many of them premature deaths and continue to drag our feet on national health insurance.

I also agree with the chairman, when he said, "We must work simultaneously to fill gaps and expand coverage where and whenever possible."

Furthermore, I believe that one of the best methods to use, in order to fill some of these gaps, is to expand Medicare. Following this method will accelerate the drive for universal national health insurance by continuing to expand the role that social insurance plays in the area of health care.

The Coalition to Protect Social Security (SOS) supports the Medicare Expansion Act of 1991, because we believe that its provisions are responsive to the specific needs of a segment of the near-elderly, a group that often falls between the cracks of our present patchwork health care system, and I would like to associate myself with the comments just made by Mr. Rother relative to the testimony presented by the first witness at this hearing.

It is my privilege to serve as the chair of a panel of experts which the Commissioner of Social Security has established to evaluate and make recommendations regarding changes needed in the supplemental security income program.

Last week, the panel held the last in a series of public hearings in Montgomery, Ala., and Atlanta, Ga. At both sites, we heard testimony from many individuals who desperately need universal access to health care. I would like to submit to you the testimony of one advocate in behalf of a client who would directly benefit from the improvements this subcommittee is considering today.

Ms. Justice, the executive director of the Care Assurance System for the Aging, in Fort Payne, Ala., stated:

> Louise Durham is 61 years old, and her husband is 68 and has been retired 7 years because of a stroke that left him homebound and confused. Their income is $744 per month from his Social Security retirement. They are over the income limit for her to draw SSI. The problem is she has terminal cancer. She has kept her private health insurance until the premiums were so high, she could no longer pay them. The policy had so many exclusions, it was not worthwhile. Their combined drug bill is over $600 per month. Because she has recently had to go back for more radium treatments, she has had to stop taking her medicine, so she could pay for her treatment. This was one of the many exclusions on her insurance policy.
>
> Two hospitals turned her away, because she could not pay cash for these treatments, and her insurance company refused to help. She is not eligible for disability

from her working years, because she has not worked 5 out of the last 10 years. Social Security has assured her that she can draw next year, when she is 62. She probably will not survive until next year.

In her oral statement before the panel, Ms. Justice provided us with a few more details. Mrs. Durham has had two mastectomies. The cancer has spread to her spine and her hips. Mrs. Durham worked for 24 years and finally left work, when her medical condition made work too difficult. However, because it took her doctors the better part of the next decade to fully diagnose her problem, she was no longer able to meet the recency of work test for disability. If she survives, Mrs. Durham could benefit from the changes in the proposed law, because, as the spouse of a Medicare beneficiary, she would be eligible, once she became 62, for Medicare, and then could immediately purchase Medicare benefits until age 65, when they would be available without being purchased.

We appreciate that the chairman included in his statement this comment: "I fully anticipate that these benefits, if adopted by the Committee on Ways and Means, will be financed on the required pay-as-you-go basis."

The passage of this proposal could be of genuine help potentially to several hundred thousand persons. Turning the spotlight on this group of near-elderly and acting in their behalf cannot help but underline how important it is for us as a Nation to establish and implement the right of access for all people living in the United States to adequate health care.

Thank you, Mr. Chairman.

Mr. COYNE. Thank you, Mr. Flemming.

[The prepared statement follows:]

OUTLINE OF TESTIMONY BY ARTHUR S. FLEMMING, CHAIR, SAVE OUR SECURITY COALITION, FORMER SECRETARY OF HEALTH, EDUCATION, AND WELFARE

I. Introduction

A. Thank you for the opportunity of participating in this hearing on the Medicare Eligibility Expansion Act of 1991.

1. I concur, Mr. Chairman in your statement that "the absence of universal national health insurance is a national disgrace."

a. Furthermore, I believe that we should address the issue with a sense of urgency.

b. It is unconscionable for us to watch millions of our people experience unnecessary suffering and many of them premature death and continue to drag our feet on national health insurance.

2. I also agree with your statement that "we must work simultaneously to fill gaps and expand coverage where and whenever possible."

a. Furthermore, I believe that one of the best methods to use in order to fill gaps is to expand Medicare.

b. Following this method will accelerate the drive for universal national health insurance by continuing to expand the role that social insurance plays in the area of health care.

B. The Coalition to Protect Social Security (S.O.S.) supports the Medicare Expansion Act of 1991 because we believe that its provisions are responsive to the specific needs of a segment of the near-elderly--a group that often falls between the cracks of our present patch-work health care system.

II. Body

A. S.O.S. enthusiastically supports the provisions of the proposed Medicare Eligibility Act that would achieve the following results:

1. Waive the Medicare waiting period of two years for disabled persons age 62-64.

2. Allow persons age 62 to 64 the option to buy-in to the Medicare program if they are receiving retirement benefits under Title II of the Social Security Act.

3. Allow spouses of Medicare beneficiaries age 62 to 64 and dependent children of Medicare beneficiaries the option to buy-in to the Medicare program.

B. We also support the provision in the proposed law that would reduce the cost of buying into the Medicare program for the beneficiaries covered by the proposed law.

1. In 1992, for example, the premium for Part A would be $57 a month instead of $177 a month.

2. There would be no change in the Part B premium.

3. This change for Part A would mean, however, that the beneficiaries under this proposed law would be paying the same percentage of average lifetime Medicare benefits as is now paid by the average Medicare beneficiary.

C. It is my privilege to serve as the Chair of a panel of experts which the Commissioner of Social Security has established to evaluate and make recommendations regarding changes needed in the Supplemental Security Income (SSI) program.

1. Last week, the panel held the last in a series of public hearings in Montgomery, Alabama and Atlanta, Georgia. At both sites, we heard testimony from many individuals who desperately need universal access to health care.

2. I would like to submit to you the testimony of one advocate in behalf of a client who would directly benefit from the improvements this Subcommittee is considering today.

3. Ms. Jonnie Justice, Executive Director of the Care Assurance System for the Aging and Homebound of DeKalb County in Fort Payne, Alabama, stated:

> "Louise Durham is 61 years old. Her husband is 68 and has been retired 7 years because of a stroke that left him homebound and confused. Their income is $744 per month from his Social Security retirement. They are over the income limit for her to draw SSI. The problem is she has terminal cancer. She has kept her private health insurance until the premiums were so high she could no longer pay them. The policy has so many exclusions it wasn't worthwhile. Their combined drug bill is over $600 per month. Because she has recently had to go back for more radium treatments she has had to stop taking her medicine so she could pay for her treatments. This was one of the many exclusions on her insurance policy.
>
> "Two hospitals turned her away because she could not pay cash for these treatments and her insurance company refused. She isn't eligible for disability from her working years because she has not worked 5 out of the last 10 years. Social Security has assured her she can draw next year when she is 62. Louise probably will not survive until next year..."

4. In her oral statement before the Panel, Miss Justice provided us with a few more details.

   a. Mrs. Durham has had two mastectomies. The cancer has spread to her spine and her hips.

   b. Mrs. Durham worked for 24 years and finally left work when her medical condition made work too difficult.

   c. However, because it took her doctors the better part of the next decade to fully diagnose her problems, she was no longer able to meet the recency of work test for disability: she had not worked 20 out of the last 40 quarters.

5. If she survives Mrs. Durham could benefit from the changes in the proposed law because as the spouse of a Medicare beneficiary she would be eligible once she became 62 for Medicare, and then could immediately purchase Medicare benefits until age 65 when they would be available without being purchased.

D. We appreciate, Mr. Chairman, that in your statement accompanying the introduction of this bill you said: "I fully anticipate that these benefits, if adopted by the Committee on Ways and Means, will be financed on the required pay-as-you-go basis."

III. Conclusion

A. The passage of this proposed law could of genuine help potentially to several hundred thousand hundred persons.

B. Turning the spotlight on this group of near-elderly and acting in their behalf cannot help but underline how important it is for us as a nation to establish and implement the right of access for all people living in the United States to adequate health care.

Mr. COYNE. Ms. Jones.

STATEMENT OF MARY GARDINER JONES, CHAIR, PUBLIC POLICY COMMITTEE, OLDER WOMEN'S LEAGUE

Ms. JONES. Thank you, Mr. Coyne.

I am speaking here this morning for the Older Women's League—OWL. We represent many of the women who will be substantially helped by this particular bill. But before I go into my support for the bill, which we do support, Mr. Coyne, I want to tell you about our convention that we had this summer. I wish that Dr. Wilensky had been here and been at the convention when she talked about the administration was waiting for some kind of unanimous consent on the part of the American people for health care reform.

The OWL membership, meeting in its convention, voted unanimously that they wanted to work for universal comprehensive health care publicly funded and publicly administered as OWL's first priority.

Given that, nevertheless, we believe that your bill should be supported and we are supporting it, because it does make some step towards enlarging the coverage of the people who currently are without health insurance and cannot get health care in this country. So, although we are urging you to take on the larger problem of universal health care, we support this approach and are happy to see that you are taking this action.

Essentially, the bill will respond to people in this country who are not in the workforce, women who have been widowed, women who are divorced, women who are working in lower-pay jobs, where their companies do not give them health insurance. If they are working in jobs where they get health insurance, as dependents of their spouses, they are now facing the increasing trend which we see, and that is that companies are now cutting back on the benefits that they are giving to dependents. So, the group of women that we represent are seriously harmed by not having access to the kind of health insurance they need.

I thought it would be useful to the committee, if I just read you a few of the letters that we have received, to give you a sense of the kind of situation that our members are confronting in trying to face their problems of health care.

One widowed OWL member recently wrote us:

> I lost my husband 4 years ago, at the age of 57. I was operated on 6 months later for colon cancer. This outside world is new to me, because I was a homemaker for 36 years. I am not working yet, so I find the health insurance is so expensive, if you can find a company to accept you. My COBRA has expired, so I am on my own.

She would be helped by this legislation.

A dental hygienist from California wrote:

> It is the custom to employ hygienists by the day, so that no benefits need be paid. I have been paying $509 per quarter for health insurance. This premium has been raised to $1,062.

When Dr. Wilensky talked about the incentive of this bill to push for early retirement, I would like to say that, for OWL members, early retirement is a first-class problem. This is not the problem our members face. Our members face trying to find jobs, trying

to beat down the discrimination about the elderly, so that they can go to work. This is not a problem that they face in terms of having unequal incentives to retire.

In summary, I want to say that this is a bill that we support. It will respond very directly to the needs of many of our members, but we hope very much that, in working on this bill, this committee does not lose sight of the larger problem which will only be solved when we have a comprehensive health care. Medicare is the cheapest, most cost-effective system, and until we get a system which is publicly funded and publicly administered, when we can save the $25 to $40 billion that we are spending on administrative costs, then we will have real cost containment within a single-payer system.

Thank you, Mr. Coyne.

[The prepared statement follows:]

Testimony of Mary Gardiner Jones
before the
Subcommittee on Health
of the
Committee on Ways and Means
Subcommittee on Health
March 19, 1991

CHAIRMAN STARK, AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE:

Thank you for providing the Older Women's League (OWL) the opportunity to testify today. OWL commends the Chairman for his continued leadership to increase access to health care for the uninsured.

My name is Mary Gardiner Jones. I am a member of OWL's board of directors. Founded in 1980, OWL is the first national grassroots membership organization to focus exclusively on issues of concern to midlife and older women. Through education, research, and advocacy, we work for public policy changes to reduce the inequities women face as they age.

OWL has pledged to work to achieve a national, publicly financed and administered universal health care system accessible to all. It is OWL's conviction that a universal health care system must be given first priority by Congress. Our national goal must be protection for all Americans against the devastation caused by lack of adequate medical care and high costs. Nevertheless, OWL supports the reforms proposed under the Medicare Eligibility Expansion Act of 1991 as an essential expansion in Medicare coverage and an important first step toward achieving univrsal health care in this country.

I. THE PROBLEM

If enacted, the Medicare Eligibility Expansion Act of 1991 would provide Medicare coverage to 1) early retirees receiving Social Security benefits; 2) spouses and dependents of Medicare beneficiaries; 3) individuals entitled to Social Security benefits, but not yet covered by Medicare. Thousands of older women who belong to each of these groups desperately need the expanded access to Medicare coverage proposed in this bill because they have no other source of affordable coverage for their multiple health care needs.

A substantial proportion of older women have no health care coverage from any source, public or private. According to 1989 Census Bureau statistics, 1.5 million women between the ages of 55 and 64 had no health insurance coverage. This figure represents 11.5% of the total number of women in that age group. For older minority women, the health insurance picture is particularly bleak. A woman's chances of being left out of health insurance coverage increase dramatically if she is black or Hispanic. 261,000 or 22% of black women between the ages of 55 and 64 have no health insurance coverage. For Hispanic women, the problem is even worse. 28.7% of the Hispanic women in this age category have no health insurance coverage.

There are several reasons why older women cannot obtain health insurance through the private market. In 1987, only 30%, or about 3.4 million American women between the ages of 55 and 64

were insured through an employer as workers. First, fewer of them work in full-time, full-year jobs offering health insurance. In 1987, only 26% of women in this age group worked full-time, compared to 53% of the men. Those that do find work are likely to be employed in part-time positions which rarely offer health insurance benefits. They are more likely to work for small companies, which often do not offer health insurance coverage. In addition, they are more likely to be employed in the clerical, administrative, and service sectors of the economy, which offer few benefits to workers. Finally, they are also more likely to leave employment providing health insurance to care for an ailing spouse or relative.

Although 3.4 million women in the 55-64 age group receive health insurance coverage indirectly as spouses or dependents of workers, they are still vulnerable to the loss of this coverage. Many companies have cut back on dependent coverage as a way of coping with soaring health care costs. In addition, many older homemakers may lose health insurance coverage upon losing a spouse through death or divorce. Although some women may become eligible for continued health insurance coverage under COBRA, such coverage is limited. First, they are eligible only if the husband's employer employs 20 or more workers. In addition, the employer may require them to pay both the employer share as well as the employee share of the premium, which can make such insurance prohibitively expensive for older women on fixed incomes. And coverage is limited to a maximum of 36 months.

Individual private health insurance plans do not afford a solution for older women. These policies frequently deny or limit coverage for pre-existing medical conditions. Women tend to have more chronic illnesses and to have resulting limitations requiring longer periods of care than men. Thousands of midlife women who suffer from heart disease, cancer, diabetes, and other serious health conditions cannot obtain individual health policies at any price. Preventive services -- including mammograms and pap smears-- may not be covered.

Even when older women can purchase health insurance, the cost of insurance can devastate their financial health. Their costs include high premiums, as well as deductibles, and co-payments. They may also incur additional expenses for services not covered under their plans. However, many older women do not have the financial resources to pay for this coverage. In 1988, the median annual Social Security benefit for non-married women between the ages of 62 and 64 was $4,652, or approximately $387 per month. In December, 1990, the average monthly benefit for a disabled woman was $463, and for a disabled widow, it was $368.90. Clearly, out-of-pocket health expenses may put both employer-sponsored and individual health insurance beyond the reach of many older women.

Finally, public programs do not meet the needs of many uninsured older women. An older woman between the ages of 62 and 64 must meet Social Security disability standards and undergo a 24-month waiting period before she can qualify for Medicare coverage. To obtain Medicaid, she must be disabled and poor. As the figures on the uninsured cited above demonstrate, these programs do not currently meet the needs of many older women.

II. WITNESSES TO THE PROBLEM

OWL's files are replete with letters from older women describing their problems obtaining health care coverage.

One widowed OWL member recently wrote, "(I) lost my husband four years ago at my age of 57. (I) [w]as operated on 6 months later for colon cancer. This outside world is new to me because I was a 'homemaker' for 36 years. I'm not working yet, so I find the health insurance is so expensive (if you can find a company to accept you.) My COBRA has expired, so I am on my own."

A dental hygienist from California wrote OWL that, "it is the custom to employ hygienists by the day so that no benefits need be paid...I have been paying $509.00 per quarter for health insurance, this premium has been raised to $1,062 per quarter!"

An OWL member, divorced after a 29 year marriage, began doing temporary work. "I had to find my own [health insurance] and it was very difficult. A few months ago I found a company that would insure me...I found that when I submitted a claim, they paid such a small amount that the $500 deductible may never be reached and then last week I received a letter from them that they are increasing the premium another $40 a month. I cannot afford that and I don't quite know what to do about it."

III. THE SOLUTION

The Medicare Eligibility Expansion Act of 1991 would provide incremental improvements to women who are most in need of the health coverage at a rate that is more affordable to them than individual insurance on the open market.

The bill would expand access to health care coverage in the following ways:

1) eliminate the waiting period for Medicare entitlement for disabled persons aged 62 or older;

2) permit those who are at least 62 and collecting Social Security old age benefits but not eligible for Medicare to purchase Medicare coverage at affordable rates;

3) expand Medicare enrollment eligibility to spouses of Medicare beneficiaries age 62 or older and to their children who are under age 18.

OWL favors the enactment of all these provisions as a critical step toward universal access to health care coverage. Under this bill, a basic package of Medicare benefits would become available to thousands of older women who cannot obtain or afford private health insurance.

OWL also supports the "buy-in" provisions of the bill, which would make Medicare coverage affordable for early retirees and spouses and dependents of Medicare beneficiaries. Again, because so many women in the 62 - 64 age group live on low fixed incomes, the combined costs of Medicare Part A hospital insurance, $177 per month in 1991, and the Part B premium, are prohibitive. Adjusting the Part A premium to $57 per month in 1992 would make this coverage affordable for this group.

Finally, OWL supports waiving the 24-month waiting period for Medicare for individuals entitled to disability benefits beginning at age 62. This group is least likely to obtain private health insurance, because their disabilities would be considered pre-existing conditions likely to bar them from most forms of private insurance.

Again, thank you for the opportunity to present this testimony and for your concern about this issue. We look forward to working with the Chairman and his staff to expand access to Medicare for these particularly vulnerable groups.

Mr. COYNE. I want to thank the panel for your testimony and indicate that it is very encouraging to see people come and give real life examples, as Mr. Flemming and you, Ms. Jones, have given, instead of statistics. While statistics are important and we hear an awful lot of them, your testimony that cited real-life examples are very useful to the committee.

I want to ask Ms. Jones about Dr. Wilensky's testimony and her concern over the fact that this would lead to early retirements. Are you concerned about that?

Ms. JONES. No, on the contrary. As I said, our experience is that our members are desperately trying to keep their jobs, to find jobs, so that they can pay for health care. Even with Medicare, they are paying 50 percent of their expenses. So even when this group of people that you are trying to include under the Medicare system get included, they will still have enormous medical bills to pay, so early retirement is not an issue for our members. It is working that is an issue for our members and finding ways to pay for their health care.

Mr. COYNE. Would anyone else want to comment on that concern that Dr. Wilensky had?

Mr. FLEMMING. I was interested in that dialogue, but it seems to me that as a nation we have established the right for early retirement, as we express it. In other words, we have established the right of persons to begin to draw reduced benefits at age 62. And why we should react in a negative way in terms of the situation that they confront because they exercise that right is hard for me to understand.

There are many, many reasons why they exercise that right, as my colleague has brought out. The fact is that many of them are in a situation where they have no coverage as far as health care is concerned. This bill is designed to help close that gap. And I can see no connection between what this may do or not do on providing incentives to people to exercise this right that they have to retire at 62, and, the closing of the gap in the health care area as far as they are concerned.

Mr. COYNE. Again, I appreciate your citing these real-life examples. Recently, one of my constituents took an early retirement and in order to provide health coverage for him and his wife, had to take out a Blue Cross policy. He retired on a monthly income of $866 a month and the coverage with no preexisting conditions was $488 a month. That doesn't leave much for people who are retired to exist on. I thank you for those examples that you have cited here today.

Thank you.

Chairman STARK [presiding]. I apologize to the witnesses for being called away but I have had a chance to review your testimony. In Mr. Rother's testimony there is a table 1, a Lewin chart on the cost per enrollee. I presume that that is a budget-neutral or a revenue-neutral cost to the Federal Government to provide Medicare benefits. Am I correct?

Mr. ROTHER. That's correct, sir.

Chairman STARK. So if somebody my age wrote a check for a little over $100 a month, $1,365 per year to be exact, to the Government, I would be a budget-neutral beneficiary?

Mr. ROTHER. That's correct. That's the actuarial cost for that age group.

Chairman STARK. Now, let me assume further, however, the bad news is that this implies no adverse selection? That this means that everybody is in the group and not——

Mr. ROTHER. The disabled who are already in the program and who have much higher per capita costs, since they are already in the program are excluded from this calculation. So this would be the per capita cost of including those people, age 50 to 64, who are not now in the Medicare program.

Chairman STARK. OK, but what I am saying is that to get that $1,365 you have got to get everybody from 55 to 59 in the box or you would have adverse selection?

Mr. ROTHER. That's certainly true.

Chairman STARK. Which leads me to a question for which I am afraid that I know the answer. Why don't you offer your own coverage as you now provide, I guess, underwritten by Prudential Bache, for your supplemental. Why doesn't AARP just run that and offer an insurance policy to its younger members?

I presume the answer is adverse selection?

Mr. ROTHER. Actually we have been pushing the Prudential Bache quite vigorously to do just that. And they now have a test program in three cities offering our younger members major medical coverage which is the only thing that might even be affordable. I would be pleased to ask them to furnish the committee with their results which I am afraid are not that encouraging because of the adverse selection problem—which means you have to underwrite—and also because of the very high cost of providing not supplemental but primary coverage.

Chairman STARK. That brings me to my next bill. If you think the administration does not like H.R. 1444, wait until they see what we should do to solve your problem. That is health insurance reform which makes every health insurer, including the self-insured big companies, meet the standards that Blue Cross now has agreed to meet for tax exemption, that is, no medical underwriting, no community rating, and open enrollment at all times.

Now, if every insurance company has to do that, then there can be no adverse selection, right?

Mr. ROTHER. That's the theory, right.

Chairman STARK. And the risk pool becomes what, the community at large?

Mr. ROTHER. Right.

Chairman STARK. So we don't need a fancy Federal risk pool, we have just created it. AARP can offer this policy if the Federal Government does not.

So I hope to see you all back here supporting that and that would be helpful.

Mr. Flemming, you brought up Louise Durham as an example in your testimony of somebody who was unable to get care, two hospitals who turned her away. Mr. Donnelly, of our committee, is going to introduce or has introduced legislation which would say that either one of those hospitals should lose their tax exemption or their ability to participate in Medicare if they refused care.

Do you think that in addition to providing insurance that we just ought to get a lot tougher in not allowing hospitals to turn anyone away?

Mr. FLEMMING. Mr. Chairman, you are referring to part of my testimony and this grew out of the fact that I am chairing a group for the Commission on Social Security to take a look at SSI. We have been holding some public hearings. We held hearings in New York, Chicago and Los Angeles, and last week in Montgomery and Atlanta and the testimony to which you refer was presented to us at that time.

Louise Durham was represented by an advocate who presented the facts regarding her case. I included it in my testimony because it seems to me that your bill can be of real help to situations of this kind. But in response to your question, yes, I would personally favor getting tougher on the kind of situation that confronted her when two hospitals turned her away. I do not know just how Congressman Donnelly proposes to go about it and I would like to have the opportunity to take a look at his proposal. To me this is a rather unconscionable situation.

Ms. JONES. May I speak to that for a minute?

Chairman STARK. Please, and speak to one other thing while you are considering that. If we take the Secretary's advice and question the expansion of Medicare to the near-elderly, would your organization support expanding Medicare to cover children and mothers? Would I be correct in assuming we would have your groups saying, fine, you want to do them first, we will pitch in.

I find that the senior organizations to be much more flexible in that than the administration and I wonder if you concur. But go ahead and answer the question.

Ms. JONES. You are absolutely right, Mr. Chairman. We are grandmothers, we are mothers. That is why at its convention OWL did not take a position on increasing catastrophic for themselves; they did not take a separate position on long-term care. They took a universal comprehensive position that what we need in this country is comprehensive care. Picking and choosing among different groups in this country is unconscionable.

The only thing I wanted to comment on the hospitals was, that I think again, the problem with the hospitals is that they are not getting compensated for unreimbursed care. I don't think that we can punish them more when we have not got a system that enables everybody to get care regardless of what particular group they fall into. We are spending more money administratively in figuring out whether they belong in group A or group B or group C which we could save and start to insure them. So my only caveat on going after the hospitals in a heavy manner, they are having a terrible time. They are going bankrupt. In this city alone——

Chairman STARK. Not as bad as you would like to think. Let me just give you the news from the hospital community because people always bring this up. There are 53 hospitals closed in 1990 out of 6,000 that is not bad. And of those that closed more than half were government or investor-owned. Only about 22 of the 50 were operated by nongovernment or not-for-profit and not-for-profit organizations. But keep in mind 43 hospitals were opened. It is arguable that more should close.

Ms. JONES. Yes, but I am concerned with the hospitals in Washington, D.C., the hospitals in Michigan where they have to bring suits to get better reimbursement because they were going broke in trying to give care. I think that we have to look at the whole system.

Mr. ROTHER. Mr. Chair, if I could, just a personal story on your question on children. I worked in the United States Senate as a staffer for 8 years. I was privileged to work for the first 4 of those years as health staff to Senator Jacob Javits. The very first bill that he had me draft on his behalf was a national health insurance for women and children bill which I still think is a pretty good piece of legislation and I would be delighted to work with the committee. Our approach, at AARP, I think is consistent with almost all the senior groups we now work with: health care reform that benefits all age groups. I think the obvious places to start are where the vulnerabilities are the greatest and that is pregnant women, children and those elderly who are among the groups here that this bill would address.

Chairman STARK. All I can say is right on.

Mr. FLEMMING. Mr. Chairman, one of the reasons I am delighted to have the opportunity to participate in the drive for national health insurance with universal right of access is that it is an intergenerational issue. It involves all age groups. All age groups are suffering because of our failure to come to grips with this issue in an effective way.

Chairman STARK. Quite right.

Mr. Moody, would you like to inquire, please?

Mr. MOODY. Thank you.

I am sorry I had to be out of the room for much of your testimony, we have two sets of hearings this morning, Human Resources and Health Subcommittees.

I gather the four of you are supporting this initiative.

What did you think of Dr. Wilensky's criticisms that this was marginalism, this was tampering at the margins and possibly taking us in the direction that we did not want to end up going?

Ms. JONES. Well, it's not marginalism in that sense, although I tried to stress that for OWL's purposes we are supporting comprehensive universal health care. So it is hard for us to take a small piece of it when what we want is the whole. But we looked at this and we thought that this bill moves us towards that. It is not inconsistent with it. It is taking in one more group and it is giving them universal health care. So, for us, yes, it is too small but it needs to be done. We have to move this way so that we support this bill.

Mr. MOODY. It is hard to imagine any comprehensive bill that would not end up covering people between 62 and 65.

Ms. JONES. Exactly.

Mr. MOODY. So, I found her criticism to be a bit strange intellectually that we can't do this because we don't have a master plan yet, and our master plan which she admits is not here, and hopefully will be, may take us in a different direction. But it is hard to imagine a master plan that would actually not cover this group.

Ms. JONES. Well, her the master plan is going to raise the Medicare eligibility age up to the retirement age, then she is going in the other direction.

Mr. MOODY. I suppose.

Ms. JONES. But I don't think we can permit that.

Mr. MOODY. Right. She could not be accused of inconsistency for the fact that in the works is a plan to raise Medicare eligibility up to 67. I suppose that is the one outlet you might say she has.

Do the other gentlemen have a comment?

Mr. ROTHER. Congressman Moody, I think if there is anything that has been the root of our problems in health policy for the last 10 years it is a budget-driven perspective—because you are only looking at part of the system and ignoring all the rest. I think that Dr. Wilensky's comments are an example of that kind of budget-narrow perspective. It is silly to look at the actuarial status of the HI trust fund and then base health policy entirely on that, when all you are doing by doing that, is creating more serious problems for the rest of the system. You have to look at the whole thing at once. I think that a bill along these lines is consistent with that, but we would echo the Older Women's League in saying that we would prefer a more comprehensive approach that deals with the issues of cost containment, universal access and long-term care as a part of a package.

Mr. MOODY. Well, you heard my point to her that if health care is cost effective, if insurance is cost effective because it induces the behavioral response of coming in earlier and stressing prevention——

Mr. ROTHER. That was a well taken point.

Mr. MOODY. Then is it really cost effective denying insurance to people from 62 to 65? And if it is, and if budgetary considerations are real, then why don't we start denying them up to 67 or 69 or some other number?

Mr. ROTHER. Not only is it not cost effective, but it is inhumane. We are talking about people's lives being a risk when there is no need for that.

Mr. MOODY. But she was taking financial flow as the criteria for whether or not this was good public policy. If you take all financial flow because of the cost shifting that goes on, are we really saving money?

Mr. ROTHER. Exactly.

Mr. MOODY. The other point she made that I would appreciate your comment on is that this will induce behavioral changes, and that people will retire earlier if they are covered this way. What do you think about that?

Mr. ROTHER. I thought your point—that that was a trivial argument—is well taken. Most of the work that has been done shows the effect of pensions and the availability of pensions and Social Security on the retirement decision. I think it is entirely inappropriate and immoral to use the availability of health coverage and the threat of complete uncoverage to——

Mr. MOODY. To keep people in the work force?

Mr. ROTHER. Yes. I think that is the wrong policy and contrary to our American values.

Mr. MOODY. It has kind of a punitive aspect to it.

Ms. JONES. Well, it is not a problem that our members face, Mr. Moody. Our members are desperately trying to find ways to pay for health care. They are trying to work and they are trying to get jobs, those that are able to. It is a first class choice for them to have the problem of whether they are going to have early retirement or not. That is not their problem.

Mr. MOODY. Right, but you would argue that if you give them health care if they retire at 62, then that will solve their problem and force them into retirement?

Ms. JONES. They are still paying such heavy bills, even with health care insurance.

Mr. MOODY. You mean because of medigap coverage and so forth?

Ms. JONES. All of that.

Mr. MOODY. I appreciate this.

Chairman STARK. Thank you and I want to thank the panel very much for participating with us.

For our final panel we welcome three witnesses. Dr. Marilyn Moon, a senior research associate with the Urban Institute; Mr. Alfred Chiplin, who is a staff attorney with the National Senior Citizens Law Center, which provides legal representation to the elderly and disabled clients nationwide; and Robert J. Myers, the former Chief Actuary, Social Security Administration.

Mr. MOODY. Mr. Chairman.

Chairman STARK. Mr. Moody.

Mr. MOODY. I just wanted to mention that I wanted to welcome to our presence my former colleague, Marilyn Moon, whom I taught with at the University of Wisconsin at Milwaukee. I am happy to have her here, and it is nice to see you.

Ms. MOON. Thank you.

Chairman STARK. Dr. Moon, do you want to lead off?

STATEMENT OF MARILYN MOON, SENIOR RESEARCH ASSOCIATE, THE URBAN INSTITUTE

Ms. MOON. Thank you, Mr. Chairman.

I appreciate the opportunity to be here today to testify before the subcommittee. The members of the last panel spoke very eloquently about the needs of the near elderly, so I will add only a few comments. One of the interesting issues that is raised by the differences between Dr. Wilensky's testimony and the testimony of the earlier panel is the dichotomy between the members of this age group. We are not talking about those who are lucky enough to retire early after doing well in the labor force. We are talking about people who retire early because they have little choice. In many cases, there older Americans had difficulty finding and keeping jobs, and they may have had health problems that have forced them out of the labor force.

Another issue, for these vulnerable older Americans is the cost of individually purchased insurance. For those who are not able to continue COBRA coverage or who never had it, the cost of individually purchased insurance can be quite high. It likely ranges between $250 and $350 a month, an amount close to what approximately one-third of early retirees get as their total Social Security

benefits. There is obviously a need to do something to make health coverage more affordable.

I would like to devote most of my comments to how this legislative proposal fits in with other reform proposals and to those elements that need further attention. As others have already said this morning, it is tempting to wait for comprehensive coverage, and for the best possible plan. But legislation aimed at the near elderly makes considerable sense as an incremental approach. It is not certainly inconsistent with other, broader reform proposals.

Using Medicare as the mechanism also makes considerable sense for this population group. This is the program that will ultimately provide coverage to these peole when they reach age 65, so it makes sense to expand Medicare than to have a separate program for them while they are unemployed and uninsured before they reach the age of 65.

This is a group that also, in large measure, shares common health problems with their counterparts in the Medicare program, certainly those aged 65 to 69.

I also believe that we should not hold one group hostage to another while designing programs to improve health coverage. Again, this is a tempting reason for inaction, but it is likely to be a formula for doing nothing for any group. Like others, I believe the health care needs of children are very important, but the health care needs of those in this age group who are not receiving help are also important.

On the other hand, the diversity in the well-being of this age group and the differences in their needs raise some problems with the proposal that deserve careful attention. Perhaps most important is how much to subsidize the purchase of Medicare coverage. Certainly some subsidy is absolutely necessary to avoid the problems of adverse selection that Mr. Stark has already mentioned. If you have a requirement that people buy-in at the full actuarial cost to those individuals who purchase this insurance, and it is the people most in need who purchase it, then the premiums will become inordinately expensive very rapidly. But a small subsidy does not solve all of the problems of ensuring coverage because for those older Americans who lack insurance, the issue is more one of affordability than access.

On the other hand, a very generous subsidy creates other concerns. If it induces many who now have insurance to turn, instead, to Medicare, increased coverage of the group most in need will come at the expense of also insuring many who now have reasonable coverage. If so, we may end up with an expensive plan subsidizing many families to help a much smaller number in need.

These are important issues that deserve the healthy debate and discussion that this committee is engendering by raising this issue today.

Thank you.

[The prepared statement follows:]

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EXPANDING MEDICARE TO COVER AT-RISK OLDER AMERICANS

Marilyn Moon*

Most Americans under the age of 65 receive their health insurance through the work place. But younger and older workers are less likely to have such coverage. And older Americans, who tend to retire well before the age of 65, are at additional risk of being uninsured. Many of these individuals and their families live on modest incomes and may not receive post-retirement benefits from former employers. And they are often not eligible for either Medicaid or Medicare. These families and individuals fall through the cracks of our health care system.

While the plight of children who lack insurance deservedly receives a lot of attention, the problems of persons just below the age of eligibility for Medicare are also important. The situations that result in a lack of health insurance vary substantially across this population, but the consequences are the same: routine care is postponed or foregone and when treatment is received, health problems are worse than if treatment had been obtained earlier. Even relatively routine care may put these families at enormous financial risk.

I am pleased to be here today to speak with you about policy options for addressing the problems of these older Americans. I shall focus on three issues: 1) the nature of the problem and the potential needs for these older persons over time, 2) what we know about specific at-risk groups, and 3) how this proposal fits in with other health care reform concerns. Expanding Medicare offers an efficient means for filling the gaps, but its ultimate success will rest on the affordability of the coverage offered to these Americans and on whether the benefits will be reasonably targeted on those most in need.

THE NATURE OF THE PROBLEM

Americans just below the age of eligibility for Medicare who lack health insurance coverage represent an important portion of the uninsured. Most people receive their insurance coverage through their employers, but the proportion with insurance declines for older workers. Moreover, older workers may face fewer options for changing jobs to obtain better coverage. And early retirement, particularly if it is not fully voluntary, may remove them from access to any group coverage. Not all employers who offer insurance to their workers subsidize coverage for their retirees. In August of 1988, 10.2 percent of all persons aged 62 to 64 had no insurance from any source and another 16.9 percent relied on private nonemployer coverage. Women are disproportionately likely to have no insurance (10.9 percent) or have only nonemployer coverage (20.1 percent).

Public policy offers few solutions for this age group. The major source of protection, Medicaid, is generally not available to these older individuals unless they are disabled and qualify for Supplemental Security Income. Generally, they fail to meet the categorical requirements for Medicaid benefits regardless of their incomes or health care needs. In 1988, only 3.6 percent of those aged 62 to 64 had Medicaid. This group may get some relief from legislation passed in 1985 to require employers to allow employees who leave the firm or dependents who have a change in status (such as divorce or being widowed) the option of buying into the group health plan (referred to as "COBRA protections"). There are limits on such coverage ranging from 18 to 36 months.

But most important, these benefits may be too expensive for such departing workers who must pay the full costs of the coverage. Survey data from the Health Insurance Association of America indicates the average monthly premium for a conventional group plan was $119 for individuals and $268 for families in 1989. Employees eligible for COBRA protections would have to pay 102 percent of these costs.

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*Senior Research Associate, The Urban Institute. The views expressed in this statement are those of the author and do not necessarily represent those of The Urban Institute, its trustees, or its sponsors.

Privately purchased nongroup coverage would likely be much more expensive. This age group has substantially higher health expenditures on average than younger families and individuals, and the cost of individually purchased policies normally varies by age. The Congressional Research Service has estimated that age-rated premiums for persons aged 60 to 64 would cost over twice the national average. In addition individual policies tend to be substantially more expensive than group plans. Thus, if nongroup insurance is experience rated, costs to early retirees for individual coverage could be $250 to $350 per month. Affordability issues can thus extend to families with incomes well above the official poverty thresholds. Nonetheless, a large number of persons in this age group do buy individual coverage, probably amounting to a considerable share of their incomes.

For those without any coverage, a bout of illness may result in financial devastation. And recent studies have demonstrated the negative health outcomes for the uninsured who may delay getting care or who become indigent patients.

Another potential source of problems arises for those who have health problems that limit their ability to receive coverage. If an individual retires from a job that offered no insurance, the individual cannot rely on COBRA to give them access to group insurance. And individual nongroup insurance is not just expensive, it also often excludes coverage for pre-existing conditions for a period of time (for example, a year or in some cases indefinitely). Moreover, some commercial carriers will decline to insure such individuals altogether.

These problems are unlikely to improve on their own. Indeed, the situation will probably deteriorate over time. The high costs of offering retiree health coverage to employers means that this benefit is more likely to be reduced than expanded in the future. Recent polls indicate that employers are considering limiting benefits by raising required premium contributions and/or tightening eligibility requirements (such as years of employment by the firm).

For individuals, the higher costs of health care will mean higher premiums for individual policies or policies available from their employers through COBRA. Health care costs are rising about twice as fast as the average incomes of Americans so that individuals who currently can barely afford coverage will find it increasingly difficult to maintain these expenses over time. Further, restrictions by insurers on pre-existing conditions may limit the types of coverage that individuals can obtain. Given cost pressures, these limitations are also likely to be applied more frequently unless there is substantial insurance reform.

Finally, as yet there is no indication that Americans are choosing to remain on the job and postpone retirement. Persons in poor health or who are laid off never have much choice about the retirement decision. For them, early receipt of Social Security is often their only option for income. Thus, for the foreseeable future, the gaps between employer-based coverage and Medicare eligiblity will continue and may even increase.

SPECIFIC GROUPS AT RISK

Several different groups of Americans in their early 60s are particularly at risk. These groups are briefly described below:

Early Retirees. The typical image of an early retiree is a person with generous pension benefits and employer-subsidized health insurance coverage; in fact, the generosity of these benefits often help induce such workers to retire before becoming eligible for Social Security. But there is another type of early retiree who has much less choice in the timing of retirement and who likely has neither a pension nor good health benefits. For example, a majority of early retirees have no other pensions. These individuals may have faced a period of unemployment before deciding to take reduced Social Security benefits, or they may have health problems that make continuing in their current jobs untenable. They may have had only sporadic periods of employment or have worked in jobs without insurance. These are the individuals who end up without health insurance and who represent the dark side of early retirement.

For these involuntary early retirees, Social Security benefits will be less than if they had postponed retirement and the lack of private pension coverage to supplement incomes

means that many in this category rely mainly on their Social Security checks. In 1988, over one-third of all early retirees had benefits of less than $350 per month.

The cost of individually purchased nongroup plans could well exceed the size of the Social Security benefits for a substantial minority of early retirees. And even individuals who have access to less expensive COBRA coverage might still find it prohibitively expensive.

Spouses and Dependents of Medicare Beneficiaries. Another group of older persons at risk are some of the spouses and dependents of Medicare beneficiaries. Spouses, usually wives, may have no independent source of health insurance. If these spouses are not employed or employed in jobs that offer no insurance, they would only be able to purchase insurance in the individual market. COBRA coverage from the other spouse may help in these situations, but unless the wife is close to age 65, the benefits may run out, leaving her with the same problems as early retirees who have no access to group coverage. Care may be unaffordable or even unavailable for persons with health care problems. On the other hand, not all dependents are in need of help. For example, many spouses may still be in the labor force and have their own sources of insurance.

The Disabled. Persons who qualify for Social Security disability must still wait for 24 months to obtain eligibility for Medicare. During that waiting period, the lucky ones may have private coverage or be eligible for Medicaid. COBRA protections, for example, are guaranteed not to run out during the waiting period. But for those who do not have access to COBRA or other group insurance, finding insurers who will cover a totally and permanently disabled person may be difficult indeed. Almost by definition such individuals will have important pre-existing conditions that may preclude them from buying coverage or from getting insurance to cover the problems that they have. Experience from Medicare indicates that such individuals have very high levels of health expenditures.

Disabled individuals tend to have low incomes; they must be unable to work to qualify for Social Security, so unless other family members work, Social Security benefits may be the main source of income for many of the disabled. Median Social Security benefits for older disabled workers (aged 55 to 64) were $558 in 1985 and represented over half of the income received by typical recipient families.

Consequently, elimination of the waiting period for Medicare would relieve these individuals of an important burden. While this is an issue that may make sense for all disabled beneficiaries, older disabled workers are less likely to have other sources of insurance such as Medicaid.

HOW THIS PROPOSAL FITS WITH OTHER REFORM OPTIONS

The proposals under discussion here to extend Medicare benefits to older disabled workers, spouses of Medicare beneficiaries and those eligible for Social Security cash benefits would fill in some of the gaps left in our current health care system. In addition, these changes could fit in well with a variety of other, more comprehensive approaches to health reform that are also under discussion. But a key issue is the level of subsidy offered to early retirees and Medicare dependents.

It is tempting when considering what is needed for health system reform to take a more comprehensive approach and avoid incremental fixes. For several reasons, I believe that is not necessarily a valid argument here.

First, Medicare is potentially a very reasonable source of coverage for the older Americans described here today. Early retirees, spouses of Social Security beneficiaries and the recently disabled obviously have much in common with current Medicare beneficiaries. Health expenditures for 60 to 64 year olds look much like those for 65 to 69 year olds, for example. Thus, the needs of this group are quite similar to those of current beneficiaries. Moreover, the rationale for coverage is very much the same: these are people outside the mainstream of employer-covered insurance and they will ultimately receive Medicare coverage. It makes sense to create a reasonable transition to Medicare benefits for these persons, thereby eliminating the need for a separate interim type of coverage. Not only would such an approach reduce the fragmentation of coverage on an

individual level, it would use a program that has achieved considerable success in holding down administrative costs and developing cost containment strategies. Medicare thus represents an efficient potential source of coverage for these older Americans.

Second, any comprehensive reform package will need to consider how to coordinate with the Medicare program, and extending coverage to these other related groups would not further complicate that task. Indeed, some proposals would actually build directly on the Medicare program. Alternatively, Medicare coverage of early retirees would complement reforms that rely on employer mandates. Mandating employers to cover current employees represents a significant policy change; mandating that they cover retirees as well would add substantially to the burdens of many employers and is generally beyond the scope of mandating proposals.

Another policy issue often raised in considering incremental approaches is which group should be helped first. The crucial needs of children should constitute a high priority for health system reform. However, it is also undesirable to hold one group hostage to another, particularly in this case where efforts to protect children are proceeding on a different track. Expansions of the Medicaid program have quite appropriately focused on improving coverage for mothers and children. Inherently, there is no reason why improved coverage for one group should preclude that for another, and arguments about which group should be helped first may lead to inaction on all fronts.

One important aspect of how much support to offer these older Americans relates to the level of the subsidy for those who are required to buy in to Medicare in order to participate. At one extreme, if individuals were required to pay the full actuarial value of the coverage, not only would the number of people being helped be limited, but such a policy could create problems of adverse selection. Medicare coverage would undoubtedly be less expensive than individual coverage given Medicare's low administrative costs. Moreover, for those who have health problems and cannot get reasonable coverage, this proposal would be extremely helpful. But, persons who would buy in to Medicare under this type of proposal would likely represent a more expensive group to insure than many employee groups. Not only are they older than average employee groups, this option would likely attract high risk persons, further raising the actuarial costs. For many, COBRA options, if available, would be more desirable, leading to further adverse selection of the Medicare buy-in group.

At a minimum, it thus makes sense to offer some subsidy to those who buy in to limit the adverse selection problem and ensure that the public option will be at least as affordable as many employer group premiums. But a limited subsidy would not solve the problems discussed here today, because for many of the older Americans who lack insurance, the basic issue is affordability as much as it is access. Without substantial subsidies, many of the poorest members of this group will continue to find insurance unaffordable. Thus, the members of this group most at risk would likely still be uninsured.

On the other hand, a very generous subsidy creates other problems. If it induces many who now have insurance to turn instead to Medicare, increased coverage for the group that needs help will come at the expense of also insuring many who now have reasonable coverage. Employers who now offer coverage may decline to do so in the future if the Medicare option is available. Relatively well off early retirees may prefer subsidized Medicare coverage. If so, we may end up subsidizing well over a million families to help a much smaller number who are in need. And if that is the case, objections about how many resources to devote to one group of the population versus another take on more credence.

Designing policies to help a group as diverse as the near elderly poses a dilemma. The issue of whether to rely on a universal program raises issues that are now becoming familiar to debates about Medicare. Income-relating the Medicare buy-in for early retirees and dependents of Medicare beneficiaries might offer a solution to the dilemma raised here, but that option raises sensitive issues that have implications beyond this legislative proposal.

The problem faced by the legislation under consideration here is whether a reasonable level of subsidy for Medicare buy-ins could be chosen that would offer help to those who are truly in need, while limiting the number of others who forego reasonable

coverage in its stead. These are important issues that should be debated in considering how to help vulnerable older Americans and I commend the committee for its concerns and thoughtful deliberation on this matter.

Chairman STARK. Thank you. Mr. Chiplin.

STATEMENT OF ALFRED J. CHIPLIN, JR., STAFF ATTORNEY, NATIONAL SENIOR CITIZENS LAW CENTER

Mr. CHIPLIN. Thank you, Mr. Chairman.

I am Alfred Chiplin with the National Senior Citizens Law Center, here in our Washington, D.C. office. My colleagues and I work with a number of attorneys and paralegals around the country who advocate on behalf of senior citizens, many of whom are in situations who would benefit from the Medicare eligibility expansion act proposal that is before us now.

We encounter a number of situations where people are experiencing extreme hardships as they wait out the 24-month waiting period before they become eligible for Medicare. We think the elimination of this waiting period would be of great benefit for those persons.

Similarly affected are people between age 62 and 63 who, for one reason or another, have retired from employment and are without health care benefits, either because their former employment situation was not covered by the health care continuation provisions of the COBRA 1986, or because they cannot afford the cost of premiums. People in this group may or may not be disabled within the meaning of the Social Security Act, but are in need of medical care of more than a routine nature.

In any event, this group is left without health insurance protection until they reach the age of 65 and are eligible for Medicare. Access to health care for this group will be enhanced if they are able to purchase, or buy into the Medicare program at a modest cost beginning at age 62. Our same comment holds true for the spouses of Medicare beneficiaries and for children of Medicare beneficiaries. We, too, support the notion of an intergenerational approach to looking at the expansion of Medicare to cover more groups and to expanding to a more universal access system.

We are also excited to note that this legislative proposal is mindful of the high cost of buying into the Medicare program, given its current structure. We are pleased that the committee is considering ways in which the costs might be lowered, including modified premiums on the part A side. As you know, adding together the current $177 a month premium for the uninsured person who buys Medicare, plus the part B monthly cost would make that very, very expensive for a number of our clients, most of whom are at or below the poverty level.

We are also concerned that the committee consider expanding its proposal to include coverage for people age 60 through 65. This group, like the 62 to 64 age group are also in need of health care coverage. They are experiencing many of the same kinds of access to health care problems that have been identified in the discussion thus far today.

We think the expansion to include this group would be a very necessary and useful approach for the committee to consider. It is, in our preliminary estimates, an expansion that would not unduly tax the system as it exists currently. Thank you.

[The prepared statement follows:]

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Hearing On
The Medicare Eligibility Expansion Act of 1991

Statement of
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HEARING BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE SUBCOMMITTEE ON WAYS AND MEANS
United States House of Representatives

MARCH 19, 1991, WASHINGTON, D.C.

Mr. Chairman and members of the Committee, the National Senior Citizens Law Center (NSCLC) is a National Back-Up Center that assists Legal Services Corporation (LSC) and Older Americans Act/Administration on Aging (AoA) sponsored legal programs across the country in providing legal representation for their elderly clients. The Law Center, with a current complement of eleven attorneys, was founded in 1972 and now has two (2) offices, one in Los Angeles, CA and the other in Washington, DC. We appreciate the opportunity to present our views on the pressing need to make the changes in the Medicare law you propose.

Ms Brewer and I are the staff persons principally responsible for the Medicare advocacy of NSCLC. Ms Sweeney handles Social Security matters, including disability issues under Title II of the Social Security Act and under Title XVI, the Supplemental Security Income (SSI) program. Advocacy activities include providing technical information to field program attorneys and paraplegias, statutory and regulatory analyses, training, and litigation support (which in some instances includes serving as lead or co-counsel in court actions).

The Problem

In our work, we have encountered numerous situations in which persons between age 62 and 64 are disabled within the meaning of the Social Security Act1, are without any form of medical coverage, and are not yet eligible for Medicare because of the 24 month waiting period2. People in this category often forego needed medical services because they are unable to afford such services or are otherwise deemed uninsurable by private insurance carriers.

1. See. 42 U.S.C. §416 (definition of disability).
2. See, 42 U.S.C. §426; 42 C.F.R. §406.12 (Medicare entitlement for disabled beneficiaries).

Similarly affected are people between age 62 and 63 who, for one reason or another, have retired from employment and are without health care benefits either because their former employment situation was not covered by the health care continuation provisions of COBRA'86[3] or because they can not afford the costs of premiums for continued coverage. (People in this group may or may not be disabled within the meaning of the Social Security Act, but are in need of medical care of more than a routine nature.) In any event, this group is left without health insurance protection until they reach the age of 65 and are eligible for Medicare. Access to health care for this group will be enhanced if they are able to purchase or "buy-in" to the Medicare program at a modest cost, beginning at age 62..

There are also spouses age 62 to 64 as well as the children of Medicare beneficiaries who are without medical coverage. For these groups, the cost of private health insurance, where available, is often prohibitive due to preexisting conditions and other encumbrances. They too will benefit from being able to buy-in to the Medicare program at a modest cost.

Proposed Solutions

The solutions set forth in the legislative proposal of Representatives Stark, Coyne and Moody, the subject of this hearing, are viewed by the Law Center and the beneficiary advocates with whom it works as positive. They will make Medicare covered health care available to a segment of our population whose health care needs are most compelling. The solutions include:

(1) waiving the Medicare waiting period for disabled persons age 62 to 64;

(2) allowing persons age 62 to 64 the option to buy-in to the Medicare program if they are receiving retirement benefits under Title II of the Social Security Act; and

(3) allowing spouses of Medicare beneficiaries who are age 62 to 64 (and dependent children) of Medicare beneficiaries the option to buy-in to the Medicare program.

We are excited to note that this legislative proposal is mindful of the high cost of buying-in to the Medicare program at its current rates: Part A premium for the uninsured at $177 per month, plus a Part B monthly premium at $29.90 in 1991. For most of the beneficiary community with whom we work, these costs, both separately and combined, are prohibitive. Thus, the notion of a modified Part A premium for these new groups of Medicare beneficiaries at approximately $57 per month, with the Part B premium amount remaining unchanged, is more affordable.

Further Expansions -- Coverage of Persons 60 60 64

The Expansion. We are also concerned that this proposal be expanded to include persons 60 to 64 hears of age. The situation for them is often akin to that of persons age 62 to 64. They too are part of the "near-elderly" population and are suffering through the 24 month waiting period for Medicare coverage. Similarly, their need for the proposed Medicare "buy-in" option is great.

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[3]. See, The Consolidated Budget Reconciliation Act of 1986 (COBRA'86), 29 U.S.C. §1161 et seq.

The Rationale. The Old Age, Survivors and Disability Insurance (OASDI) program is structured so that, as the worker or dependent of a worker ages, the lines between those who are eligible based upon their disability and those who are eligible due to age are often blurred. And, it has been our experience that after a person reaches age 62, SSA is not as inclined to encourage disability applications. In fact, over the years we have seen cases where SSA has discouraged the disability application, instead telling the person simply to seek old age benefits.

While there is some cash disadvantage to taking early retirement old age benefits, for many of these individuals, the key loss is Medicare. (However, even with disability insurance, the current two year wait for Medicare eligibility means that a person who applies at age 62 for disability (and is determined to be disabled) will not be entitled to Medicare until age 64.

There are three (3) key problems which arise for persons ages 60-65.

(1) They receive an old age benefit rather than a disability benefit.4 So, even allowing for the problems which the two year waiting period would create if they could get Medicare, they can not get Medicare until age 65.

(2) Many of these individuals, both men and women have impairments which do not rise to the level of being disabling under the statute but which nevertheless prevent them from working and result in substantial health costs for which they have no health care coverage.

(3) Many of these women are not widows and do not have work records of their own for disability purposes. If they were not married, they would probably receive SSI disability benefit and therefore be able, in most states, to get Medicaid. However, because she is married and she and her husband receive a Social Security benefit on his record, their combined benefit most often makes them ineligible for SSI benefits and Medicaid.

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4. In the case of a widow, she may have been eligible to receive Social Security widows' disability benefits prior to age 60. In that case, after she met the two year waiting period for Medicare, she would be entitled to Medicare. However, if the same widow with disabilities applies for Social Security after she is 59, she will receive an old age benefit. While she is entitled to receive Medicare (after a two year wait) if she is able to establish her disability, see 42 C.F.R. §406.6(d)(2), these women are frequently not aware of this rule and end up without Medicare until age 65.

In OBRA '90, Congress eliminated the very restrictive definition of disability which widows had been required to meet. §5103 of Public Law 101-508, amending 42 U.S.C. §423(d)(2)(A) and repealing §423(d)(2)(B). Widows must now meet the same test as workers in establishing disability: "any substantial gainful activity." The result should be, that with appropriate publicity by SSA and HCFA, widows who are receiving old age benefits, who are ages 60-64, will be more easily able to prove disability. This will not, however, remove the two year waiting period. Nor will it address the health care needs of those widows between 60-64 who have medical conditions which do not yet rise to the level of being considered disability under the statutory definition.

Slightly different factual circumstances give rise to virtually identical problems for workers who begin to receive old age Social Security benefits prior to age 65, as early as age 62. There are three (3) key problems here:

o First, there are some people, both men and women, who have worked for many years during their lives and who therefore have a work record which supports the payment of old age benefits. However, that same person may not have a work record which supports disability benefits. This may be because, due to a degenerative or undiagnosed impairment, he or she left work long before SSA would consider the condition to be disabling but at a time when work was no longer possible due to the health problems.

This person, despite severe health problems, is treated as "aged" and Medicare is not available until age 65.

o Second, there are others who have serious health problems which do not rise to the level of being disabling, but which nevertheless impair their ability work and result in uncovered health care costs.

o Third, as with the third problem listed above, as a member of a couple who is entitled to Social Security benefits, this person often is not able to qualify for SSI, not because s/he is not disabled, but because the combined Social Security benefit for the couple exceeds the SSI limits. The result is that s/he is also not eligible for Medicaid.

The irony of the current patch-work of benefits for those between ages 60 and 64 is that the disability statute and SSA's own disability policies are tilted heavily in favor of the older disabled worker. In other words, there is already a federal recognition that the closer a person is to age 65, the more likely it is that an impairment will be considered to be disabling, when also taking into consideration the person's age, education and work experience. For example, 20 C.F.R. §404.1563 is entitled, "Your age as a vocational factor." §404.1563(d) provides:

"(d) Person of advanced age. We consider that advanced age (55 or over) is the point where age significantly affects a person's ability to do substantial gainful activity... If you are close to retirement age (60-64) and have a severe impairment, we will not consider you able to adjust to sedentary or light work unless you have skills which are highly marketable."[5]

And, there are also special rules for those who have worked long years at arduous tasks.

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[5]. This rule is repeated, in slightly different terms, in the rules which accompany the medical-vocational guidelines used in determining disability. See 20 C.F.R. Part 404, Subpart P, Appendix 2, rules 201.00(d) and (f), 202.00(f), and 203.00(c).

Chairman STARK. Thank you, Mr. Chiplin.
Mr. Myers.

STATEMENT OF ROBERT J. MYERS, FORMER CHIEF ACTUARY, SOCIAL SECURITY ADMINISTRATION

Mr. MYERS. Thank you, Mr. Chairman.

As always, it is a pleasure to appear before the Committee on Ways and Means or one of its subcommittees. Before discussing the particular proposal I would like to point out that currently the financial health of the Medicare program is excellent. The Hospital Insurance Trust Fund increased by some $13 billion last year and is at a height of almost $100 billion. However, down the road, perhaps 20 years from now, the program is certain to have financial problems, especially as the baby boomers are coming along to retirement age, and, therefore, there is a much higher proportion of people who are eligible for benefits, as compared to the covered population.

I think that, before any change is made in the Medicare program, the first thing that should be done is to put a tax schedule into the law for the hospital insurance program that will show that the system is in balance over the long range, just as this committee has always done in connection with the Social Security program and in the past when Medicare was started.

The philosophy of the Social Security program in providing early retirement benefits was to make these available for people if they wanted to retire before the normal age of 65 on an actuarially reduced basis, and then the people were on their own. Many people retire voluntarily because they see little reason to work, because they have sufficient income along with their reduced Social Security benefit to get along on. They also see how little more they can earn than their reduced Social Security benefit.

However, you can't do this with a Medicare package. You can't give an actuarially reduced Medicare package—it is either all or none. I believe that the proposal should not be adopted. I think that people should not get full benefits before the normal retirement age of 65, and as that age will increase in the future. In fact, I believe that the two ages should be linked together, the minimum age for Medicare with the minimum age for full Social Security benefits, which will eventually be 67 and will start increasing from the present 65 in the year 2003. In other words, for anybody who retires early, the burden should be on them to provide health insurance.

So, unfortunately, I cannot favor this proposal. I would like to point out, with all due respect, that the proposal as written in its present form is unworkable. As I understand it, and I would be quite glad to be corrected, the Medicare benefits will be available only for people who are, according to the language in the bill, receiving benefits. I submit to you that, with the flexible retirement test under Social Security, in many cases it is impossible to say whether a person is receiving benefits or is not receiving benefits in a particular month. So, they would not know whether or not they have Medicare protection.

Let me give you a specific example. A person reaches age 62 in January and goes to the Social Security office and says that he or she wants to take reduced old age and survivors benefits. The office asks "Have you stopped working?" The person says, "No, I am going to earn $1,000 a month for the next 6 months and then in July I am going to retire completely." The Social Security Administration says, "Fine, you are under the annual exempt amount and we will pay you benefits every month this year." Then, suppose that this person in July, instead of retiring, finds a good job at $3,000 a month, and the Social Security benefits are stopped. At the end of the year, it is found that the benefits that were paid were in error, and there were overpayments, and the person must repay them. Where does this person stand under the bill as to having Medicare protection?

There are many other cases too when people receive benefits for some months of the year, but not for all months of the year because of having partial employment. It is not known which months they get benefits for until after the year is over. So, the bill, in its present form, is unworkable. The solution to this, if you were to do it, is to do as is done for people over age 65. Everybody who is over 65 is eligible for Medicare whether they are working or not. And there is the primary/secondary rules if they have health insurance from their employer.

I think that, to have a workable bill, you must do that down to age 62. I remember being in this room working on the Medicare legislation, somewhat over 25 years ago, and at that time the committee was very anxious to apply Medicare only to people who were really retired, just as cash benefits apply only to people who a really substantially retired. And there was no way that any of us could figure out how to make Medicare benefits available only with a retirement test.

Finally, Mr. Chairman, there are certain other points in the bill where the drafting could be improved. For example, I know that it is the intention to have part B, supplementary medical insurance, available for these people, aged 62 to 64. Yet, I claim that the bill does not do this. But again, that is a technical point. There are others that I point out in my testimony.

In conclusion, Mr. Chairman, I believe that certain changes in Medicare are desirable at this time, although I would not make this change of bringing in persons aged 62 to 64. One thing I would do on the negative side is to put in the law that the minimum age for Medicare benefits will track the minimum age for full Social Security benefits. The other thing that I would do, and perhaps some of you may feel that you got burned on this one before, but it is the right thing, would be to introduce some catastrophic provisions into Medicare. This is the "name of the game" of insurance, to take care of catastrophic needs. I suggest doing this and financing it partly by raising the Medicare part B premium rate a little bit and partly by moving some of the first-dollar benefits into catastrophic benefits. Particularly, I would increase the $100 deductible in part B to about $200, which is where it would be now if the original $50 that was legislated in 1965 had been kept up to date.

I would also put a small amount of coinsurance in at the beginning of hospitalization so that there would be unlimited hospitali-

zation with no coinsurance at the longer durations. Those of us who worked on the original Medicare bill made one bad mistake by not indexing that $50 initial deductible. We did index the hospital deductibles, and I think that has worked out properly. But, unfortunately, the part B initial deductible was put in as a flat $50, and there has been difficulty really keeping it up to date.

Thank you, very much, Mr. Chairman, for this opportunity to testify before you today.

[The prepared statement follows:]

STATEMENT BY ROBERT J. MYERS PRESENTED TO THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND MEANS, HOUSE OF REPRESENTATIVES, MARCH 19, 1991, WITH REGARD TO PROPOSALS TO EXTEND MEDICARE COVERAGE TO THE NEAR-ELDERLY.

Mr. Chairman and Members of the Subcommittee: My name is Robert J. Myers. I served in various actuarial capacities with the Social Security Administration and its predecessor agencies during 1934-70, being Chief Actuary for the last 23 of those years. In 1981-82, I was Deputy Commissioner of Social Security, and in 1982-83, I was Executive Director of the National Commission on Social Security Reform.

Before discussing the proposals to extend Medicare coverage to new categories of persons, I will deal with the financial status of the program. As to the Hospital Insurance portion, the current and near-future situation is excellent, from a cash-flow standpoint. The balance in the fund increased by $13 billion in 1990, and stood at $99 billion at the end of the year. This balance represented almost 150% of the estimated outgo for 1991. Income is estimated to exceed outgo by about $15 billion in each of the next four years, but by decreasingly smaller amounts thereafter. Similarly, the fund ratio will stay at about 150% for several years, but it too will then decline. Further, it is estimated that the fund balance will decrease rapidly after the turn of the century, and will be exhausted in 2003.

I believe that, before any expansion is made, the financing of the existing program should be put in good order. Specifically, under responsible pay-as-you-go financing -- in which I strongly believe for both Medicare and Social Security -- an adequate tax schedule should be legislated, instead of the present basis of having a combined employer-employee tax rate of 2.9% for all future years, which will most certainly will be inadquate over the long run. Such a schedule could be to continue the present 2.9% rate through 1994, then increase it to 3.3% for 1995-99, 3.9% for 2000-04, with further steps every five years until reaching 8.2% for 2035-39, and 8.6% for 2040 and after. In this fashion, it can well be said that the intention to finance adequately the HI program is made clear, and people can then see what its future cost impact will likely be. I recognize, of course, that future experience will undoubtedly require changes in this schedule, but at least the general nature of the costs involved will then be made clear and evident.

The Supplementary Medical Insurance program is, quite properly, financed on a pay-as-you-go basis over the future. The enrollee premium rates (and thus the matching contributions from the General Fund) are prescribed in the law for 1991-95, and are to be promulgated by the Secretary of Health and Human Services thereafter. I believe that a schedule of premium rates should be legislated for a much longer future period, or at least estimates thereof should be made public, so that the costs involved would be more visible. Incidentally, I have never seen any description of how these premium rates for 1991-95 were developed. I believe that it would be very worthwhile if this Subcommittee issued a technical report thereon.

The overriding philosophical basis for Social Security benefits has always been to pay full benefits only for retirement after the Normal Retirement Age, except as to long-term disability beneficiaries under age 65. When Medicare was enacted in 1965, this principle was properly continued. However, when the Normal Retirement Age for Social Security benefits was increased from 65 to 67 in the 1983 Amendments -- on a deferred, phased-in basis -- this was not done for Medicare, for which the minimum eligibility age was retained at 65 for all future years. It would have been desirable then to have established these minimum eligibility ages as the same for both programs, but in the "crisis" situation for Social Security in 1983, attention was devoted only to that program.

It might be logical, in theory, to pay reduced-for-life Medicare benefits to those who claim them before the Normal Retirement Age, as is done for Social Security benefits. However, in practice, it would certainly not be feasible to do so. Therefore, I believe that it is not desirable to provide Medicare benefits for non-disabled early retirees aged 62-64 until they reach the Normal Retirement Age applicable for Social Security benefits.

If full Medicare benefits were made available for persons aged 62-64, this would undesirably encourage early retirement. In my opinion, persons who retire early should take upon themselves the additional financial costs involved for both income support and medical care.

The distinguished Chairman of this Subcommittee, along with Congressmen Coyne and Moody, has introduced a bill that would make Medicare coverage available to persons aged 62-64 who are receiving Social Security benefits and who are not otherwise eligible for such coverage by being disabled beneficiaries who have been on the roll for at least 24 months. I believe that it is the intention of the bill to provide both HI and SMI coverage, but I think that the actual language does not really do so as to SMI.

Such persons would pay a monthly premium for the HI benefits ($57 in 1992, rising to $78 in 1996), plus the regular SMI enrollee premium that is paid by all other enrollees. No provision is made for financing the additional cost involved to the HI program, which is already in a precarious position over the long run. Nor is any recognition given of the additional cost involved to the General Fund of the Treasury (which currently has no extra funds available, but rather only massive deficits) for the approximately 3-to-1 matching of the SMI enrollee premiums.

Furthermore, the proposal in its present form is not administrable or operable, because of the impossibility of determining in many cases just who is Medicare eligible by being in receipt of Social Security monthly benefits and for what periods they are eligible. As a result of the retirement earnings test being on a desirably flexible basis, it is often impossible to know whether a person received Social Security benefits in a particular month until after the close of the year. For example, suppose that a person attains age 62 at the beginning of January and intends to earn $1,000 each month until July and then retire completely. Under these circumstances, the Social Security Administration would immediately begin the payment of monthly benefits of, say, $600. However, if, beginning in July, the individual gets a job at $3,000 per month instead of completely retiring, the benefits would then cease. After the year was over, the benefits that had been received for the first six months would have to be repaid to the Social Security Administration. In many cases, people receive benefits for some months of the year, but not for all months. It would certainly not be feasible to have Medicare benefit coverage only in some months of the year, but not all -- and, at that, in months which would not be known until the year was over.

As a result, the only practical way to extend Medicare coverage to those aged 62-64 would be the very costly procedure of covering all persons in this age group who are eligible for Social Security benefits, regardless of whether or not they are receiving them -- just as is done for the Medicare coverage of those aged 65 and over.

The bill would provide immediate Medicare coverage for disabled beneficiaries aged 62-64 after they had started to receive monthly Social Security benefits, instead of the present requirement of being on the monthly-benefits roll for 24 months. This would create vast beneficiary uncertainty (and administrative difficulties, too) as to when Medicare coverage is present -- because of the long time which is often involved before disability determination is completed and because of the possibility of delayed claims filing, because 12 months of reciprocity is permitted.

I would also point out a minor inconsistency in the bill with regard to the initial enrollment period and the start of coverage as between insured workers and auxiliary beneficiaries. For example, consider the case of a worker and spouse both of whom attain age 62 at the beginning of January, and who apply for Medicare coverage during that month. The worker's Medicare coverage starts in February, whereas the spouse's coverage starts in January.

In conclusion, I do not favor the pending proposal, but I believe that certain Medicare benefit changes would be desirable at this time. First, some catastrophic-cost benefits should be introduced into both HI and SMI. In particular, hospitalization benefits should be provided without limit and without any cost-sharing for long-duration cases. This should be financed by instituting small daily cost-sharing payments for the 2nd through the 9th days of hospitalization.

As to SMI, a catastrophic cap on out-of-pocket expenses for the cost-sharing payments should be instituted. This should be financed both by slightly higher enrollee premium rates and by increasing the annual initial deductible from $100 to $200 (which is more nearly comparable with what the $50 deductible in the original legislation would now be if it had been kept up to date with price inflation) and indexing it in the future according to changes in medical-care prices.

Second, as mentioned previously, the minimum age for Medicare eligibility for non-disabled persons should be the Normal Retirement Age for Social Security benefits (which would have no effect until 2003 and thereafter). This change would significantly reduce the relatively high payroll tax rates which, as I indicated previously, would be necessary to support the present provisions.

Chairman STARK. Thank you, very much.

Mr. Coyne.

Mr. COYNE. I have no questions.

Chairman STARK. Dr. Moon, you cite studies that refer to negative health outcomes for the uninsured. Do you think that there would be a significant reduction in this type of a problem if this limited a bill were to come into force?

Ms. MOON. I believe this bill could help individuals get care earlier, and that would lead both to some potential longer run savings in the expenses that they incur, and an improvement in the health status of those individuals. However, I agree with others on the earlier panel that it is very difficult to point to the actual dollars and cents saved and to say absolutely that you would save money. Given the way that budget dollars are counted, you would be even less likely to be able to point to savings. On the other hand, if we could do a good accounting for all of the costs of lacking insurance—that is, the social costs to the individuals and their families as well as the medical costs—better health coverage probably could be shown to be cost effective.

Chairman STARK. Mr. Myers, I am troubled, if you are worried about the trust fund going broke, I am not worried. I am not going to get into the econometric argument whether it is scheduled to go broke in 2003 or 2008. The fact is that we are not getting scored literally for cost reductions that this committee has made during the last 10 years and will presumably make into the future. Pretty soon 2003 will be 2020 and as we continue to cut from the baseline projections, we will continue to stretch that date out.

There is no indication either on the part of the administration or the majority party that we won't cut from the baseline increase every year. To assume otherwise seems to me to fly in the face of history and tradition.

But let's for a minute assume that we have to do that right now. I am still intrigued with Mr. Rother's testimony that basically says that for $1,374 a year, slightly over $100 a month, we can provide Medicare benefits—for all of their inadequacies it is a whole hell of a lot better for the doctor in the hospital than no insurance—to as many people between the ages of 50 and 64 or to everybody. Then our only problem is that if you don't have $100 a month or cannot afford that, and I would say that it is the rare employed person who cannot, but if they are below the poverty level then they will get Medicaid anyway or should be. I guess what I am saying is that in trying to be incremental and minimize the cost to the system we have tried to find those seniors who are the absolute most needy. But if that troubles people then why don't we just say—and not call it Medicare, that will keep some people happy—let's just say that everybody between 50 and 65 gets an insurance plan, and they or their employers or their tax bill is going to make them pay $110 a month and if they don't have that kind of money the Federal Government will pay the difference.

Why wouldn't the community and the country be one whole hell of a lot better off if we did that? That is the question. Mr. Chiplin, wouldn't that take care of most of the people you are concerned about?

Mr. CHIPLIN. It would.

Chairman STARK. And its cost is zero, it is budget-neutral.

Mr. CHIPLIN. It would help our community. I think one of the reasons that we talk in terms of Medicare or Medicaid is because of the programs that we know and the ones that we have.

Chairman STARK. That's right.

Mr. CHIPLIN. But any system that would provide coverage for these groups would be useful.

Chairman STARK. Precisely the reason we use Medicare here, in this, trying to spread it around. Mr. Myers, your reputation precedes you as a person who has been involved in the system far longer than I have, but it is a good system. It is the best system in the country. That doesn't say that it can't be improved upon a lot. All I am saying is that I think people would take it rather than Medicaid. The hospitals would rather have it. The doctors would rather have it. The beneficiaries would rather have it, and indeed, the States would rather have Medicare than Medicaid.

It costs a whole lot less than Aetna, Cigna, AARP's Prudential Bache policy or any other policy that is available mostly because we have no overhead to speak of. So, why not take what we have and bring more people in under the tent?

Marilyn, we have gone round and round on this in meetings with the subcommittee and meetings in public. Is there something wrong with Lewin's estimates of what this would cost or can we afford this? Can we afford not to do it?

Ms. MOON. These numbers look a little low compared to some of the ones that I have seen, but they are clearly in the ballpark. For example, the estimate for individual coverage in a good group plan is about $119 a month across all workers. For this age group, $119 is likely a little low. On the other hand, this figure includes private sector administrative costs and Medicare has been more successful in holding down such costs.

Thus I believe Lewin's estimates may be a little optimistic but this would certainly be affordable insurance. Medicare does have the advantage of being a very efficient program. The question is how to best make use of it to help the people most in need.

Let me add that the major concern about offering blanket protection under Medicare to people age 50 to 65 arises if we are going to continue to depend upon employer-group health insurance. Those over age 50 constitute a large chunk of the labor force. Since one of our major problems in health care is fragmentation, we could contribute to the fragmentation that employers face by reducing their risk pools and consequently make the situation for employer-provided coverage worse.

Chairman STARK. Well, as you know, it is my thought, and hope that what we would basically do is obviously expand this to everybody. In other words, the employment based system is vestigial, it just doesn't work. How do you allocate employers to kids? You just can't do it. There is no logical way to get access, universal access through the employment based system, which has changed since the 1940s when it was invented. Families have changed. Kids have either no parents or more parents than they know what to do with during the course of their adolescence. The parents are fighting about who gets the kid on weekends and then they are fighting the other way to say who has to pay for the kid's health insurance.

They don't want them both. They want the kid on the weekend and they want the other parent to pay for the health insurance. The courts are jammed with people arguing that one. I have to ask why? Why should Chrysler get stuck paying for the kids when the father works for the foundry and doesn't have insurance. It is not logical. Why don't we insure all of those kids, or why don't we insure all of those people who are not working? Then let's back up and figure out how to pay for it. That could run to the employers.

I have no quarrel in suggesting that the payroll tax, higher minimum wage in the form of minimum benefits for the McDonalds and the retailers and the service employees or the people who work part time. I don't know, Mr. Myers, where those $3,000 a month jobs are for the people that we hope to cover. If they can afford to get into that, it is not $3,000 a month if they are field workers in California and it is not $3,000 a month at McDonald's. It is not $3,000 a month waiting on trade at the Radio Shack. It is not $3,000 a month being a rent-a-cop or taking tickets at a parking garage. The standard kind of employment that takes people just above the Medicaid qualification by a long way, that is $2,000 a month missing and also missing is any opportunity. There is no health insurance. I am not saying if they can afford it they shouldn't buy it, I believe in that, but it just isn't there.

That is the group, below $1,000 if you don't live in Mississippi or Alabama or some place like that, you qualify for Medicaid. It is above the $1,000 per month income bracket where the people are hooked. This is the area where the gaps must be filled.

Mr. MYERS. Mr. Chairman, the example I gave was admittedly a simplified one to show the point clearly. But believe me, there are many, many people between ages 62 and 65 who work sufficiently so that they get benefits only part of the year. It is that which creates the technical difficulty that I see as to people having—or not having—Medicare benefit protection throughout the year.

Chairman STARK. You are absolutely right and that's why we should have my bill. Every resident in the United States should qualify for the plan, whatever that plan is. That is not going to be such a generous plan, $600 first day hospital deductible, $100 and 20 percent of the doctor's bill, no prescription drugs. I mean this is a long way from being a very generous plan, if you are poor. I am just saying it is not so bad if you have the current buyin or insurance and copay payments that we provide for poor people who qualify for Medicare. But then everybody is in. Now, all we have to fight about is what kind of a supplemental, what kind of a medigap you want. That is what my union would bargain for. That is what I could get to pick as a Federal employee out of that Chinese menu of benefits that I have to look at each year and not understand. There will still be room. We are not going to be able to do it all. Some of the members of this subcommittee would like to, but politically I just don't think we are going to get there.

I appreciate your testimony, you pointed up some interesting drafting concerns that your expertise helps us resolve. I appreciate your joining with the rest of the panel to sort of point us in the right direction. But if we can make a little bit of progress maybe we will still arrive by the end of the decade with universal access

and reasonable and affordable health care for everybody. I hope you will stay with us and see how it comes out.

Thank you, all, very much.

[Whereupon, at 12:34 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT BY THE ARTHRITIS FOUNDATION
ON EXTENDING MEDICARE COVERAGE TO THE NEAR-ELDERLY

The Arthritis Foundation is a national voluntary health agency, with 71 chapters. We represent 37-million Americans with arthritis, a painful chronic illness that frequently leads to disability.

We are pleased to have the opportunity to submit this statement for the March 20, 1991 record of the hearing on "Proposals to extend Medicare coverage to the near-elderly." This statement reflects the Arthritis Foundation's views on legislation that would reduce the 24-month waiting period before Social Security disability beneficiaries qualify for Medicare. The Arthritis Foundation wholeheartedly supports legislation that would gradually reduce the 24-month waiting period until, ideally, it coincides with the time that social security disability benefits begin.

As the system operates today, individuals do not become eligible for Social Security Disability Insurance until five months after they are officially declared disabled. Such disabled individuals then wait another 24-months to become eligible for Medicare. Thus the waiting period is often 29 months long.

The Arthritis Foundation believes that this 29-month waiting period is unacceptable as a matter of public policy and economics. It creates a catastrophic health-care void for individuals whose condition demands immediate treatment.

Disability in many cases leads to loss of employment, and consequent loss of the health-care coverage provided by employers. The self-employed who rely on Social Security disability benefits as their source of income are no longer able to afford health insurance premiums. Thus at the precise moment when health care is most needed, and most required to prevent further physical deterioration, it is out of reach.

Studies of employment loss among individuals with rheumatoid arthritis support this conclusion. These studies showed that within a decade after onset, the prevalence of work disability, defined as total cessation of employment among those working premorbidly is no less than 51% and may be as high as 59%. Another study, analysing the 1976 National Health Interview Survey, found that 10% of those with a musculoskeletal condition and a work history who were less than 65 were no longer working. These conditions thus have extraordinarily high work disability rates.

The paper in The Journal of Rheumatology in which these studies were reported; also estimated that the person with rheumatoid arthritis faces:

* three times the medical care costs of an age and sex-matched population,
* perhaps twice the rate of hospitalization,
* four times the number of ambulatory visits,
* six times the probability of severe activity limitation,
* four times as many restricted activity days,
* as much as 10 times the work disability rate.

Putting these two factors together -- a high rate of employment and insurance loss among workers with arthritis and a high demand for medical services -- it is easy to see that the denial of access to Medicare to the disabled for up to 29 months is a true hardship.

Indeed, estimates for past surveys indicate that approximately one-third of new Disability Insurance Benefits beneficiaries are uninsured at some time during their waiting period for Medicare. A more recent Social Security Administration report suggests that beneficiaries living in a lower income household are more likely to be without health insurance. And the effect of this deprivation is magnified by its consequences.

Withholding Medicare benefits from persons who have been determined to be too disabled to work may reduce their chances of medical recovery by allowing the disease to proceed unchecked. It interferes with their return to work and intensifies existing hardship.

Further, those without medical coverage are very likely to be unable to purchase coverage because their condition makes them uninsurable. These individuals are trapped in a Catch-22 situation where neither the public nor the private sectors will assist them unless they "spend down" to meet their state's Medicaid eligibility requirements.

Many of these individuals simply wait out the 29-month gap without medical care. Their medical conditions may worsen during this time and in turn adversely affect their long-term prognosis. Ironically, Medicare often ends up paying more to treat severely disabled beneficiaries than would have been required for necessary medical care during the 29-month delay. In the case of arthritis, for example, limiting access may delay treatment until more expensive procedures, such as joint replacement, become necessary.

Even those individuals who are able to obtain private insurance may not be reimbursed for their health-care costs. The costs of the medical services they receive often are not covered because of deductibles, coinsurance, exclusions, and other limitations. In addition, it is likely that arthritis would be considered a "pre-existing condition" disqualifying them for reimbursement.

Disabled individuals with arthritis, children and adults, need continuous long-te.m care coverage consisting of extended personal, social, and health-care services in the home and community. Preventive services and non-institutional care are particular needs. Like individuals with other chronic, disabling medical problems, many people with arthritis do not seek such care during the 29-month-long waiting period.

For these reasons, the Arthritis Foundation , whose mission includes advocating the interests of people with arthritis, strongly urges reducing the waiting period. In the long run, unmet health needs do not represent a savings for the health care system. On the contrary, the costs mount with the pain and discomfort endured, transforming trivial procedures into major surgical ones, inexpensive treatments into costly drug therapy, and increasing the degree of disability to levels where expensive long-term care is needed.

ILGWU
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COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

Testimony in conjunction with
Hearing on Proposals to Extend
Medicare Coverage to the Near-Elderly

Held March 19, 1991, 10:00am

Consistent with the International Ladies' Garment Workers' Union's (ILGWU) advocacy of national reform of our nation's health care delivery system, we support passage of federal legislation that expands access to Medicare coverage.

The ILGWU firmly believes that, in the long run, it is only a single payor social insurance model of a national health program that can begin to cure the underlying sickness afflicting our current system. Nevertheless, we welcome and support all efforts to make health security more available to greater segments of our population, especially the disabled and older workers and their families. The United States can no longer afford the burden of a system under which tens of millions of Americans are left with inadequate or no health services - a situation which continues to deteriorate as unemployment rises and the population continues to grow and age.

While the ILGWU has a distinguished record of developing health services for its members, having established the first union operated health care center in 1914 and founding one of the first multi-employer financed comprehensive health programs in the early 1940's, the current environment of uncapped rising health costs emphasizes the inability of any one single industry or sector to provide and maintain access to affordable quality health care.

As labor intensive jobs are lost, washed overseas or shifted into unorganized areas with no health benefits, more and more American men, women and children are deprived of the most basic health care protection. Currently, the unemployment level in the apparel industry is nearing 10%. Last year almost 25,000 ILGWU members were dropped from union rolls. Of the more than 6,500 workers (90% women) who retire each year, over 66% retire before reaching age 65.

On loss of employment and income, disabled and under age 65 workers and their families cannot afford COBRA continuation coverage, even at lower group rates. A disabled worker must wait until the sixth month of disability before beginning to receive monthly benefits and then must wait another twenty-four months to qualify for Medicare coverage.

We applaud, as a step in the right direction, the proposals to eliminate Medicare waiting periods for the disabled and to permit workers under age 65 to buy into Medicare for themselves, their spouses and dependent children.

Robert L. Lessne, Ph.D.
Vocational Rehabiliation,
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The following is a proposal to the committee to expand the Medicare program to include services to blind and visually disabled persons.

It is most important that health care porviders and the general public recognize visual impairment as a disability. The goal is to authorize payment under the medicare program for services provided by qualified and certified orientation and mobility specialists (Peripatologists) and rehabilitation teachers.

These services would be extremely valuable to blind and deaf-blind persons, enabling them to function more independently, thereby reducing future medical and home care expenses. Orientation and mobility training will help prevent the institutionalization of older and near-old blind persons, and make employment possible.

Orientation and mobility techniques were first developed by Dr. Richard Hoover for the blinded veterans of Wold War II. These techniques were adapted and are still used by the Veterans' Administrations today. Steadily rising are graduate and undergraduate programs for the training of orientation and mobility specialists and rehabilitation teachers.

According to the National Society for the Prevention of Blindness there are close to 500,000 blind persons in the United States of whom, 265,000 are 65 years of age or older. The rate of blindness in our nation is 2.25 per 1,000 of the general population for all ages, and 12.38 per 1,000 for individuals 65 years and older.

From the Statistical Abstract of the United States (1990), 12.9% of persons with visual impairments lived in communities outside of nursing homes or other institutions, 13.4% of the population lived alone, and 12.6% lived with others.

There is a serious shortcoming in present Medicare provisions which cover numerous paramedical services for elderly and disabled persons but do not authorize payment for the most valuable services a visually impaired person can receive, those of a certified orientation and mobility specialist or therapist, whose teachings would offer the client a new found indepence... the ability to walk and mobilize safely and efficiently.

Orientation and mobility techniques provide freedom of movement to develop or continue with everyday activities such as shopping, housecleaning, even cooking and socializing. The rehabilitation teacher helps minimize the effects of blindness by teaching such personal management skills as eating, dressing, cooking, cleaning, writing, reading (braille), etc.

Presently, Medicare will cover the costs of physical therapy, speech pathology, occupational therapy, and other essential services designated to allay the disabling effects of stroke, paralysis, or loss of clear speech. However, should blindness occur, the services of a qualified allied health professionals such as an orientation and mobility specialist or rehabilitation teacher are not covered.

This is a gross inequity and I urge the committee to support legislation to assure that these valuable services be included in your considerations.

Some of the provisions of the Americans with Disabilities Act will bring to light the gross exclusion of services for blind and deaf blind persons. It is projected that the ADA will open the door for thousands of blind persons wishing to enter or return to the world of work. Orientation and mobility training will be necessary for those seeking employment, and those wishing to continue to live independently, thus saving millions of dollars of institution costs and bringing tax payers back into the fold.

Orientation and mobility training and rehabilitation teaching would provide incentive and confidence for further education and vocational training, and alleviate the need for attendant care.

The Bureau of Policy Development of the Health Care Financing Administration indicates that the statutory provisions of section 4106 (a)(1) of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508), which amended section 1842 (b)(4) of the Social Security act to specify Medicare payment methodologies for services furnished by certain health care practitioners, makes no provisional changes in the scope of covered services.

As The Bureau of Policy Development does not have the administrative discretion to extend Medicare coverage, My request on the behalf of blind and visually impaired persons everywhere is that legislative action be taken to amend the Social Security Act to authorize direct payment of orientation and mobility training and rehabilitation teaching under Medicare... that you bring light into their darkness.

Most cordially,

Robert L. Lessne, Ph.D.
Orientation and Mobility Specialist

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STATEMENT OF NATIONAL ASSOCIATION OF REHABILITATION FACILITIES CONCERNING PROPOSALS TO EXTEND MEDICARE COVERAGE TO THE NEAR-ELDERLY BY THE COMMITTEE ON WAYS AND MEANS, SUBCOMMITTEE ON HEALTH

This statement is submitted on behalf of the National Association of Rehabilitation Facilities (NARF) for inclusion in the record of the Subcommittee's hearing of March 19, 1991 regarding proposals for extending Medicare coverage to the near-elderly and certain other groups.

NARF is the principal national membership organization for medical, vocational and residential rehabilitation facilities. Its medical membership includes most rehabilitation hospitals and a substantial number of rehabilitation units in general hospitals, as well as a large number of outpatient medical rehabilitation facilities. Most, if not all, of these member institutions are qualified as providers of services under the Medicare program. Often the failure of disabled people to obtain timely and comprehensive medical care, including medical rehabilitation, leads to greater long term disabilities than would otherwise be the case. The provision of rehabilitation services can reduce dependency and reduce the potential for further acute care. Conversely, failure to provide such services in a timely manner is pennywise and pound foolish. For example, the present requirement for a two-year waiting period after a finding of disability for Medicare coverage virtually guarantees that Medicare will not pay for rehabilitation services, but only for more chronic acute care often arising from disabilities.

We agree with the statement of the Chairman in announcing this hearing, that the absence of universal health insurance is a national disgrace. The consequences are not only felt by the uninsured population. Lost productivity, increased dependence and long term disability all flow from our failure to deal with this problem.

The focus of the Subcommittee on expansion of Medicare coverage to certain groups is to be encouraged. This statement will be primarily addressed to these groups, persons receiving SSDI benefits. This group is one with which NARF member facilities have considerable experience, both as medical patients and as clients of vocational programs.

Presently SSDI beneficiaries become eligible for Medicare benefits only after a waiting period of two years following a determination of disability. The effect of this policy is to virtually guarantee that timely rehabilitation services will not be financed through the Medicare program. In many cases persons who become disabled and thus qualify for SSDI benefits do not have health care coverage at the time their disabling conditions appear, or such coverage does not include rehabilitation services. As a result they do not receive either medical or conventional rehabilitation services in a timely manner. By the time Medicare coverage becomes available two years later, the opportunity for effective rehabilitation is diminished, if not lost for good. This makes no sense.

NARF has long advocated immediate Medicare coverage for persons judged to be disabled under SSDI. The Subcommittee's press release of this hearing indicates that this group numbers only 75,000 people. Adding this number of people to the Medicare rolls would have a marginal impact on the program's cost, but a tremendous effect for the people involved. The issue for this group is not just the provision of ongoing health care services. Providing coverage of medical rehabilitation services in a timely manner would reduce the likelihood of long term dependency and recurring acute care. This would likely result in a net reduction in health care costs.

Expansion of Medicare coverage to this group should be complemented by modification of the present policy for provision of vocational rehabilitation services to SSDI beneficiaries. Presently the Social Security Administration is authorized to make payment for such services to states for persons who return to substantial gainful employment as a result of vocational rehabilitation services through the State-Federal program under the Rehabilitation Act. This policy has been in effect since 1981. Prior to that time SSDI trust funds were available to provide rehabilitation services independent of the VR program.

The result of this change has been to reduce the number of SSDI beneficiaries receiving rehabilitation services. There is tremendous potential for reduction of cash assistance to SSDI beneficiaries through the timely provision of rehabilitation services. This can be achieved through either or both of two changes in current law: immediate provision of Medicare coverage upon a determination of disability and/or reinstitution of the program for paying for rehabilitation services as delivered to such beneficiaries.

NARF strongly supports the elimination of the two-year waiting period for Medicare coverage of SSDI beneficiaries. This course is not only good for the people to whom such coverage would be provided, but it would reduce dependency and the burden on the SSDI Trust Fund of continuing cash assistance.

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Statement for the Record
for the
House Committee on Ways and Means
Subcommittee on Health

April 1, 1991

hearing on

"Proposals to Extend Medicare Coverage to the Near-Elderly"

by Martha Keys
Vice President
Public Affairs

of the

National Multiple Sclerosis Society

Mr. Chairman and members of the Subcommittee, my name is Martha Keys. I am the Vice President for Public Affairs of the National Multiple Sclerosis Society, and I thank you for this opportunity to submit testimony as a follow-up to your hearing on "Proposals to Extend Medicare Coverage to the Near-Elderly." As a former member of the Subcommittee, I have a special appreciation of the scope and importance of your jurisdiction.

Multiple sclerosis is a chronic, often disabling neurological disease affecting more than a quarter of a million Americans. Each week approximately 200 adults in the prime years of employment and productivity, are newly diagnosed. In MS, the protective coating surrounding nerve fibers in the central nervous system (spinal cord and brain) is damaged. This interrupts and distorts nerve impulses. The effect is similar to a short circuit in an electrical wire. MS symptoms vary widely and may include at one time or another pathological fatigue, impaired vision, loss of balance and muscle coordination, slurred speech, tremors, stiffness, bladder and bowel problems, and, in the most severe cases, paralysis. There is as yet no known cause or cure for multiple sclerosis. There is no way to prevent MS or to predict what course the disease may take.

Most people diagnosed with MS are non-elderly adults. Many who become disabled come out of the workforce. Approximately one-third, or 64,000, people with MS are Social Security Disability Insurance (SSDI) beneficiaries. I would like to focus my testimony on one major problem faced by individuals who will eventually become eligible to receive SSDI and therefore Medicare - the terrible burden of the twenty-four (24) month waiting period.

The problem as we see it is two-fold. First, a person who leaves employment due to a condition that is permanent and totally disabling leaves when they most need medical coverage. Second, despite the extended period of COBRA for those eligible for SSDI, the 102% cost of picking up one's employer's health insurance plan is often staggering because the individual must pick up the amount previously paid by the employer. Furthermore, one who is leaving employment because of the permanent disability generally has little or no income during the waiting period. It is not uncommon for us to hear people worry about paying for their mortgages or rent and food, let alone health insurance.

We recognize that current federal budget constraints limit the consideration of immediate elimination of the 24-month waiting period. However, the long-term costs to individuals' health and financial survival of a 24-month waiting period is also unacceptable. Therefore, we strongly urge you to consider eliminating the waiting period a month (or months) at a time over a period of several years. In this way an acceptable policy will be created with both the health and well-being of the disabled individual in mind and pragmatic respect for the budgetary realities.

I thank you again for this opportunity to express our concern about this piece of the larger issue of extending Medicare coverage for the near-elderly. We can assure you that the problem affects all those entering into the SSDI benefits program, not just those with MS. We hope you will consider the gradual elimination of the waiting period.

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